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A Grounded Theory Analysis of Therapeutic Interventions Practiced by Professionals in India and the UK with Child and Adolescent Survivors of Sexual Abuse

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Declaration

I hereby declare that this thesis has been composed by me and is entirely my own work. No part of this thesis has been submitted for any other degree or professional qualification.

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Abstract

There is a high prevalence of child sexual abuse (CSA) in India and the UK (Laccino, 2014). However, there is a lack of research on culturally-specific aspects of psychotherapy offered to child and adolescent survivors of CSA in both these countries. Therapeutic interventions with sexually abused children raise complex concerns due to the heterogeneity based on the developmental stage of children; varied impact, presenting difficulties and needs; and characteristics of abuse, age, gender, ethnicity and cultural factors. Numerous therapeutic interventions for CSA have been documented, with varying theoretical constructs, structure, content and outcome (Reavey & Warner, 2001), ranging from cognitive behavioural, psychoanalytic, humanistic and feminist paradigm (Misurell, Springer, & Tryon, 2011). Most of these approaches do not provide sufficient guides to therapy (Reavey & Warner, 2001). Few of these are widely studied and clinically accepted, while most lack empirical evidence. Although existing studies conclude that therapy is better than no treatment, there is lack of consensus on treatment characteristics important in child and adolescent sexual abuse therapy (Hetzel-Riggin, Brausch, & Montgomery, 2007). Further, little is known about culturally-specific holistic and coherent responses to CSA.

A Constructivist Grounded Theory (Charmaz, 2006) study was conducted to investigate therapeutic approaches practiced by professionals in India and the UK with child and adolescent survivors of CSA, and to understand the factors that govern the choice of an approach or model adopted. In-depth, semi-structured interviews were undertaken with 32 professionals (16 each in India and the UK) from different settings including statutory, voluntary and private sector. NVIVO 10 was used for data management and analysis of the digitally recorded and transcribed interviews.

Although there is a growing emphasis on evidence-based therapies, with most empirical studies focussing on traditional forms of psychotherapy, the actual practice of the professionals interviewed reflected a more fluid, flexible, multi-modal, ecological and integrative approach to CSA-therapy. The findings indicate that the therapeutic interventions progress through four different phases, based on the goals identified by professionals. The goals in turn are influenced by the socio-cultural context, structural factors, and/or trauma understanding of the professionals. Four phases identified in the study are: 1. Social Action Framework, with the goal to identify silenced and invisible children, particularly in a culture of silence and suppression in India; 2. Stabilisation and Resilience Building Framework, found to be practiced in India and the UK, with the goal to ensure safety and build the foundation for ensuing phase of therapy; 3. CSA-Trauma Resolution Framework, where the goal is to uncover the sexual abuse details to facilitate recovery and reintegrate the traumatised child, more visible in therapeutic practice in the UK; and 4. Maintenance and Relapse Prevention Framework, with the goal to prevent relapse and protect from revictimisation and future developmental difficulties. These phases may be mutually exclusive, follow a linear trajectory, or there may be a back and forth movement from one phase to the other. These four phases were integrated to construct a culturally relevant, ecological-based theoretical model of CSA therapy with child and adolescent survivors.

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List of Abbreviations

AAT	: Animal Assisted Therapy
APA	: American Psychiatric Association
CAMHS	: Child and Adolescents Mental Health Services
CBT	: Cognitive Behaviour Therapy
CCT	: Child Centred Therapy
CGT	: Constructivist Grounded Theory
C-PTSD	: Complex Post Traumatic Stress Disorder
CPG	: Cross Party Group
CSA	: Child Sexual Abuse
CT	: Complex Trauma
DCSF	: Department for Children, School and Families
DfES	: Department for Education and Skills
DH	: Department of Health
DSM	: Diagnostic and Statistical Manual of Mental Disorders
EMDR	: Eye Movement Desensitisation and Reprocessing
GP	: General Practitioners
GT	: Grounded Theory
HM	: Her Majesty
IAPT	: Improving Access to Psychological Therapies
MH	: Mental Health
MWCD	: Ministry of Women and Child Development
NCCMH	: National Collaborating Centre for Mental Health
NICE	: National Institute for Health and Care Excellence
NGO	: Non-government organisation
NHS	: National Health Service
NSPCC	: National Society for the Prevention of Cruelty to Children
NST	: Nondirective Supportive Therapy
POCSO 2012	: The Protection of Children from Sexual Offences Act 2012, India
PPCT	: Process, Person, Context and Time

PSE : Personal Safety Education

PTSD : Post Traumatic Stress Disorder

RAP : Recovering from Abuse Program

RCT : Randomised Controlled Trials

TAU : Treatment as Usual

TF-CBT : Trauma Focussed Cognitive Behaviour Therapy

UNCRC : United Nations Convention on the Rights of the Child

UNICEF : United Nations Children's Fund

UK : United Kingdom

VO : Voluntary Organisations

WHO : World Health Organisation

WLC : Wait-list control

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Chapter One

Introduction

"Many children are treated each year for mental health problems associated with abuse, however, it is unclear how many of them receive state-of-the-art, 'abuse specific' mental health treatment."

(Saunders, Berliner, & Hanson, 2003, p. 5)

1.1 Background to the Study

A number of children in India and the UK are presumed to be living with the aftermath of child sexual abuse (CSA) given its high prevalence in both the countries. India and the UK are reported to be among five top countries with high prevalence rates of CSA (Laccino, 2014). 1 out of every 2 children in India (Ministry of Women and Child Development; MWCD, 2007) and 1 in 20 children in the UK are reported to have experienced some form of sexual abuse (Radford et al., 2011). About 50% of these children in India and more than 90% in the UK were sexually abused by an adult who was known to them or was in a relationship of trust. Over the past few decades, considerable research on the impact of CSA has been conducted and published (Paolucci, Genuis, & Violato, 2001). This research has revealed short-term and long-term consequences in children and adolescents (Putnam, 2003) in any or all domains of functioning and development such as physical, neurological, behavioural, psychological, cognitive, social and interpersonal (Cook, Blaustein, Spinazolla, Van der Kolk, 2003; Hevey & Kenward, 1992). Although severe symptomatology associated with CSA may not be seen in all child and adolescent survivors, damaging outcomes are reported in a large number of these survivors, often extending in adulthood (Trask, Walsh, & DiLillo, 2011), regardless of the age or gender (Chen et al., 2010). Its effects are reported on children who experience CSA-trauma directly as well as those affected by it (Coren et al., 2009). Thus, early intervention is considered significant for preventing negative short-term and long-term effects of CSA on children and adolescents (Trask et al., 2011).

Some of the aforementioned impact of sexual abuse on children and adolescents and their families was observed directly through my work with a non-government organisation (NGO; a term commonly used in India for voluntary or third sector organisation). I worked with an NGO in India for over eight years on the issue of CSA and largely focussed on child and adolescent survivors. I also worked in South Asia with children and young girls who were survivors of human trafficking for sexual exploitation. I was involved with many child and adolescent survivors and their families, usually over a number of years with each of them, and provided legal, emotional, psychological, social and educational support as appropriate. On many occasions, I found it difficult to appropriately deal with the difficulties manifested by children and/or their families affected by CSA, such as repeated aggressive episodes, constant running away, self-harm, relationship difficulties within the family, and other extreme psychological reactions. Attempts to seek specialist therapeutic and mental health intervention for them often failed, due to the lack of services or heavy reliance on medical models and pharmacology by the few existing mental health professionals. Quick psychiatric diagnosis and long term medication prescribed to children as young as 8 or 9 years old did not prove to be helpful for most children and often their difficulties deteriorated. At the same time, by attending different conferences and seminars, there was a growing awareness about the emphasis on evidence-based psychotherapy practice in more developed nations such as the United States of America (USA) and the United Kingdom (UK). These past work experiences and gaps observed in the therapeutic practice with CSA survivors in India became the motivation to undertake this study. I was keen to understand various approaches to psychotherapy available and practiced with child and adolescent survivors of CSA, including the notion of evidence-base and its application in real practice by different professionals.

A review of literature was undertaken regarding different approaches to psychotherapy and trauma theories in general as well as specific therapeutic approaches for CSA-therapy with children and adolescents when designing this study. Further, various empirical studies that assessed the evidence-base of these approaches for CSA therapy were reviewed. A range of therapeutic approaches and

modalities for therapy with child and adolescent survivors were identified. However, empirical studies on effectiveness of various therapeutic approaches for CSA-therapy were found to be limited. Most of the empirical studies evaluated the effectiveness of cognitive and behavioural therapies (Lalor & McElvaney, 2010), and no controlled studies were found on many other therapeutic approaches such as the psychodynamic therapy (Parker and Turner, 2013). At the outset, cognitive behaviour therapy and trauma-focussed cognitive behaviour therapy seemed to the most-effective interventions for addressing symptomatology associated with CSA including post-traumatic stress symptoms (Greenspan, Moretzsohn & Silverstone, 2013). However, a deeper analysis of various, although limited, systematic reviews and meta-analyses revealed inconclusive evidence-base for CSA-trauma therapy, as significant benefits and support for one treatment approach or therapeutic modality over the other were not confirmed (Harvey & Taylor, 2010). Uniform and/or culturally-specific guidelines to therapy or therapeutic approaches were also found to be missing (Hetzel-Riggin, Brausch, & Montgomery, 2007). Further, most of the controlled empirical studies were found to be conducted in the USA (Harvey & Taylor, 2010; Macdonald, Higgins, & Ramchandani, 2006; Macdonald et al., 2012) and there was information lacking about the actual therapeutic practice in the 'real world' or clinical settings (Lev-Weisel, 2008).

A clear need was identified to understand the actual practice of different practitioners who provided CSA-specific therapy services to children and adolescents both in India and the UK (CSA sub-group, 2010; Deb & Mukherjee, 2011). Considering the high prevalence of CSA in both these countries, its impact on child and adolescent survivors, significance of early intervention as well as lack of empirical studies and information on the actual therapeutic practice in India and the UK, this study was considered extremely significant and timely. Since the gaps noted in current therapy services for CSA survivors in India prompted the study to begin with, I also wanted this research to have practical implications for policy and practice. After identifying gaps in literature, the need for greater research on the topic to inform policy and practice was deemed extremely relevant. Hence, this study was designed to develop a

culturally relevant theoretical model of CSA-therapy with children and adolescents based on the research findings.

1.2 Research Aim and Questions

The study set out to explore the therapeutic approaches and models practiced with child and adolescent survivors of CSA in India and the UK by professionals in different settings including statutory, voluntary sector and private practice. Considering the increasing emphasis, despite limited information, on the practice of evidence-based therapeutic approaches for CSA-therapy, following research questions were explored in the study by adopting a constructivist grounded theory approach:

1. What therapeutic approaches and/or models are being practiced in CSA-therapy with child and adolescent survivors by professionals in different settings (statutory, voluntary sector and private practice) in India and the UK?

2. What factors govern the choice of a therapeutic approach or model practiced by the professionals?

Based on the findings, the study sought to develop a theoretical framework or model of culturally relevant approaches to therapy with child and adolescents survivors of CSA.

1.3 Terminology

A few terms that are used consistently throughout the thesis are discussed below. Other specific terms have been discussed in the thesis, where relevant.

1.3.1 Children, Adolescents and Young People

The United Nations Convention on the Rights of the Child (UNCRC), ratified by India and the UK in 1992 and 1991 respectively, defines a child as a "person under the age of 18, unless national laws recognise the age of majority earlier" (Office of the High Commissioner for Human Rights, 1989, Article 1)". Although anyone under the age of 18 is considered to be a child in India and the UK, there are variations in the age limits as defined in different legislations and circumstances in both these countries (Bajpai, 2007; NSPCC, 2015). However, within the child protection guidance, a child is considered to be anyone under the age of 18 both in India and the UK (Bajpai, 2007; The Juvenile Justice (Care and Protection of Children) Act 2000, India; NSPCC, 2015, UK). Similarly, within the Child and Adolescent Mental Health Services (CAMHS), anyone under the age of 18 is covered (Davidson, 2008). Hence, the same definition is adopted in this study.

Further, adolescents refer to children above the age of 10 years (Hagel, Coleman & Brooks, 2013). The term young person/people has also been used sometimes to refer children between the age of 14 and under the age of 18 in the UK (Children and Young People Act, 1933, UK). Considering the developmental challenges associated with CSA, it was important to stay mindful of these differences throughout to ensure that the therapeutic approaches for children of all age groups were covered and emphasised.

1.3.2 Survivors

The term survivor is used in the thesis to refer to children and adolescents who have experienced sexual abuse. It is often used for individuals who are experiencing or living with consequences, including mental health problems or difficulties, of a life event such as child sexual abuse, and is considered to be an empowering terminology compared with 'victim' that implies a more passive sufferer connotation (Mental Health Foundation, 2012). The term survivor is used interchangeably with 'sexually

abused children and adolescents' and 'children with sexual abuse experiences' in the thesis.

1.3.3 Professionals

The term professionals in the thesis refers to the providers of therapy services to child and adolescent survivors of CSA in any setting such as statutory, voluntary sector and private practice. Other terms such as practitioners, therapists, mental health professionals and counsellors have also been used to refer to these professionals. However, the terms mental health professionals and therapists specifically have been used to refer to those professionals who were found to be qualified in specific therapeutic discipline to provide therapy (Nelson-Jones, 2011), such as clinical psychologists, art and/or play therapists, and child and adolescent psychiatrists.

1.4 The Structure of the Thesis

Chapter One provides the background of the study and the research context as well as the research aim and questions, and clarifies the key terms used throughout the thesis.

The review of literature on CSA is presented in Chapter Two. It includes the prevalence of CSA globally as well as in India and the UK, impact on children and adolescents, and different therapeutic interventions for CSA identified in the literature. Empirical studies on various psychotherapeutic approaches and modalities have been discussed. Gaps in existing knowledge about the therapeutic practice with child and adolescent survivors of CSA were also identified, including the limitations of existing empirical studies. Based on these gaps, the rationale for the study is provided, including selection of India and the UK for the study.

The research methodology is discussed in Chapter Three, which includes the rationale for adopting the qualitative research design and constructivist grounded

theory for the study. The detailed application of constructivist grounded theory for data collection and analysis is discussed. Further, ethical considerations, concerns regarding quality of the study, as well as the limitations of the study are also considered.

The findings of the study are presented in Chapters Four to Eight. Chapter Four provides an overview and context of the findings. Four key conceptual categories developed based on the findings illustrate that the therapeutic interventions with child and adolescent survivors of CSA progress in phases or stages based on their cultural context, circumstances and specific therapeutic needs as perceived by the professionals. Each phase of intervention is discussed in Chapters Four through Eight respectively, and includes the professionals' frame of reference or understanding that governs their practice.

The conceptual categories developed based on the data generated were integrated to construct a theoretical model, 'Systems and Stages of Stability', which is presented and discussed in Chapter Nine. The theoretical model illustrates a culturally and developmentally sensitive, ecological, stage-based framework of therapeutic practice for CSA with children and adolescents.

Chapter Ten concludes the study with reflections on implications of the findings for practice, policy, and further research as well as dissemination and knowledge exchange concerns.

Chapter Two

What Does The Literature Tell Us?

"*Much work remains before the best type of therapy for each child and youth survivor of CSA is identified.*"

(Greenspan et al., 2013, p. 238)

2.1 Introduction and Search Strategy

This chapter presents a critical review of the extant literature and empirical studies related to the therapeutic approaches for child and adolescent survivors of CSA. Charmaz (2006, 2014) recommends taking a critical and reflective stance towards the literature in a grounded theory study to "reveal gaps in extant knowledge" (Charmaz, 2006, p. 168) and to "weave the discussion of it throughout the piece" (p. 167). Following this stance, the literature review was undertaken twice during the study. It was done initially while developing the study proposal, before commencing data collection, in order to understand the extant theories and therapeutic practices with child and adolescent survivors of CSA. An initial skimming of the range of therapeutic approaches enumerated in the academic literature as well as their established evidence-base through empirical studies was undertaken. This helped in identifying gaps in research and "set the stage" (Charmaz, 2006, p. 166) for the study, including its context and significance. A more thorough and extensive review was undertaken after data analysis in order to contrast and compare the findings within the context of relevant literature. A number of databases were searched for the literature sources including ASSIA, CINAHL, Child Development & Adolescent Studies, Cochrane Library, EMBASE, MEDLINE, National Institute for Health and Clinical Excellence (NICE) Clinical Guidelines, PILOTS, PsycINFO, Pubmed as well as Google Scholar and the University of Edinburgh Searcher. In addition to individual studies, systematic reviews and meta-analyses were identified to examine the treatment outcomes and evidence-base of different therapeutic approaches. Appropriate references from the accessed articles were sourced when required.

Relevant government and voluntary organisation websites, both in India and the UK, were also consulted for policy documents, legislations, reports and range of therapeutic services for CSA.

The updated literature review has been integrated in this chapter emphasising the gaps in existing knowledge and research on therapeutic practices for CSA. Further, additional relevant literature was analysed and "weaved" in the emerging research findings in subsequent chapters.

The rationale for undertaking this study, including the context of the study in India and the UK, is also discussed in this chapter.

2.2 CSA: Definitions, Dimensions and Impact

2.2.1 What Constitutes CSA?

The definitions of CSA differ among researchers based on their perceptions of what constitutes sexual abuse (Macdonald et al., 2012; Manly 2005). Different definitions of CSA have been formulated (Murray, Nguyen, & Cohen, 2014; Pereda, Guilera, Forns & Gómez-Benito, 2009a) based on diverse parameters such as the age used to define a child, type of sexual abuse (i.e. contact or non-contact and degree of intrusiveness), or age difference between the perpetrator and the victim (Pereda et al., 2009a). However, the World Health Organisation (WHO) provides the following definition:

> "Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility,

> trust or power, the activity being intended to gratify or satisfy the needs of the other person (WHO, 1999, p.15)."

Use of a child for sexual gratification; elements of force, persuasion and exploitation; and power hierarchy due to age and/or relationship with the perpetrator have been emphasised in a number of definitions of CSA (Carr, 2006; Finkelhor, 1991, WHO, 1999). Further, distinctions have been drawn between contact and non-contact sexual abuse (Andrews, Corry, Slade, Issakidis, & Swanston, 2004; National Society for the Prevention of Cruelty to Children; NSPCC, 2015a); intrafamilial and extrafamilial sexual abuse (Carr, 2006); and degree of intrusiveness and frequency (Carr, 2006). Intrusiveness can range from a spectrum of viewing or exposure to sexual content to penetration. Frequency spans from a single episode to frequent and chronic abuse. The definitions of CSA in India and the UK reflect these parameters.

Definition of CSA: India

> CSA involves different forms of sexual abuse with varying degree of intrusiveness including contact and non-contact abuse. Different forms of CSA include: i. Penetrative sexual assault (penetration including inserting objects); ii. Sexual assault without penetration (involving any kind of physical contact/touch, however no penetration); and iii. Sexual harassment (includes all forms of non-contact activities with sexual intent). Consequently penalties for each vary (The Protection of Children from Sexual Offences Act; POCSO 2012).

CSA is further classified as 'aggravated' under certain circumstances such as the characteristics of the abused child and/or perpetrator or the situations of abuse. For example, it is considered to be aggravated sexual abuse when the abused child is mentally challenged or when the perpetrator is someone in a position of trust or authority in relationship to the child, including a family member, teacher, doctor, or police officer (POCSO 2012).

Definition of CSA: UK

> "Child Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse, including via the internet" (Department for Children, School and Families; DCSF, 2010a, p. 38).

Due to the difficulties in defining CSA, social norms, cultural and community standards, and social stigma that perpetuate silence make it difficult to operationalise child maltreatment including CSA (Pereda et al., 2009a; Manly 2005). This can lead to challenges in assessing its incidence and prevalence (Finkelhor 1994; Pereda et al. 2009a) as well as implications for putting policies, legislations and services in place for survivors (Murray et al., 2014).

2.2.2 Prevalence of CSA

Sexual abuse of children is reported to be widespread globally, though statistics vary between countries and reports depending on the geographic region under study, definition of CSA applied, form of CSA studied, scope of coverage, and quality of data (Andrews et al., 2004; Creighton, 2004; Pereda et al. 2009a; Singh, Parsekar, & Nair, 2014). It is recognised as a social problem affecting large numbers of children and adolescents worldwide (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Finkelhor, 1994; Friedenberg, Hansen, & Flood, 2013; Macdonald et al., 2012; Stoltenborgh, van IJzendoorn, Euser, Bakermans-Kranenburg, 2011), irrespective of age, gender, race, ethnicity, and socioeconomic status (Greenspan et al., 2013; Springer, Misurell,

& Hiller, 2012). A recent statistical analysis of violence against children by the United Nations Children's Fund (UNICEF, 2014) reveals that "slightly more than 1 in 10 girls (p. 167)" i.e. around 120 million girls worldwide, under the age of 19, have experienced forced intercourse or other forced sexual acts at some point in their lives. Similarly, Barth et al. (2013) reported that 9 girls and 3 boys out of 100 are survivors of forced intercourse and further noted mixed sexual abuse in 15% of girls and 8% of boys. Their findings are considered significant regarding the prevalence with respect to the type of abuse. Other meta-analyses (Pereda et al., 2009b; Stoltenborgh et al., 2011) covering a wider age group of survivors and spanning studies conducted within the last three decades (1980 onwards) reiterate the findings regarding prevalence among boys (8%) and a 2-3 times higher risk of CSA among females than males. However, they reported relatively higher prevalence in females, in the range of 18-20%. Children from some regions of the world are reported to be more vulnerable than others (UNICEF, 2014; Stoltenborgh et al., 2011). For example, Stoltenborgh et al. found highest rates for girls in Australia (215/1000) and for boys in Africa (193/1000) whereas lowest rates for both girls (113/1000) and boys (41/1000) were reported in Asia. However, they attributed these differences to the socio-cultural factors including a collectivist culture and taboos around sex and sexuality as barriers to disclosure and reporting in Asia. Similarly, globally lower prevalence among boys is attributed to under-reporting of CSA by them (Goldman & Padayachi, 2000) and most studies fail to capture the experiences of males adequately (Pereda et al., 2009b). Assessing prevalence in males is reported to be challenging and lack of comparable data from different countries makes it difficult to provide global estimates of CSA in boys (UNICEF, 2014). It is affirmed that the epidemiological studies have not been conducted with the aim to compare rates across a variety of cultures, and it is identified as a need for further research (Stoltenborgh et al., 2011). With regards to the perpetrators, they are most frequently reported to be close family members, neighbours, peers, and others known to the child or adolescent (Lalor & McElvaney, 2010). In majority of the cases, perpetrators are reported to be male, with estimates between 95% and 98% that have come to professionals' attention (Glaser & Wiseman, 2000).

Based on the compilation of official estimates and reports, India and the UK have been reported to be among the five top countries with highest rates of CSA, along with South Africa, United States and Zimbabwe (Laccino, 2014).

2.2.2.1 Prevalence of CSA in the UK

Referring to studies such as Baker and Duncan (1985) and BBC Childwatch (1987), Creighton (2004), reports that media funded the earliest national prevalence studies on CSA in the UK, in order to provide data for television programmes. Subsequently different researchers and organisations have conducted a number of studies on the topic, the most recent commissioned by the NSPCC. Radford et al. (2011) reported that 1 in 20 children in the UK have been sexually abused and 90% of them were sexually abused by someone they knew. Other studies confirm that, with 21% females and 11% males, two million children in the UK have experienced sexual abuse (CSA Sub-group, 2010; Cawson, Wattam, Brooker, & Kelly, 2000). Comparing findings with Cawson et al. study, Radford et al. (2011), in the second UK wide study by NSPCC, corroborate high prevalence of CSA. Radford however, suggests a decline in coerced sexual activity under the age 16 from 6.8% in 1998 to 5% in 2009. Earlier small-scale studies also confirm high prevalence of CSA in the UK. Oaksford and Frude (2001) found a prevalence rate of 13.14% in a sample of 213 female undergraduate students, reporting that 28 of them were sexually abused in childhood. More recently, quoting that the incidence of CSA was found to be "grave" and "extremely worrying" by experts, McKim (2014) reported that everyday 13 cases of child sex abuse including online abuse were handled by the police in the UK in the year 2013. Jütte, Bentley, Miller, & Jetha (2014) found more than a 9% increase in the number of sexual offences against children recorded by police in the UK in 2012/13 from the previous year. They reported that 73,900 children under the age of 16 in England and Wales and 9,100 children under 18 in Scotland reported experiencing contact child sexual abuse in the year 2012/13. Further, the compilation of statistics from the child protection registers from England, Northern Ireland, Scotland and Wales reveal that 5% (2,884) of children were subjected to child protection plans under the category of sexual abuse in the UK on 31 March 2014 (or

31 July 2014 in Scotland), which has seen an increase of 183 children from the previous year (NSPCC, 2015a, 2015b). There is lack of information and data about survivors of CSA from the ethnic communities globally (Kenny & Eachern, 2000), including different socio-economic groups in the UK (Allnock et al., 2009). Due to the lack of consensus on data collecting criteria in classifying ethnicity/racial backgrounds, as well as due to shame and denial of reporting CSA in these communities, it is considered difficult to estimate the exact incidence rates of CSA in ethnic communities (Kenny & Eachern, 2000; Malhotra & Biswas, 2005).

2.2.2.2 Prevalence of CSA in India

The research on CSA in India has not received much attention (Behere, Rao, & Mulmule, 2013; Iravani, 2011), and not much is known about the problem of sexual abuse of children (Human Rights Watch, 2013). However, the Asian Centre for Human Rights (ACHR; 2013) reports that, "sexual offences against children in India have reached an epidemic proportion (p. 1)". The first nation-wide study on CSA by the Ministry of Women and Child Development (MWCD; 2007), covering 13 states, reported that 1 out of every 2 children in schools have faced sexual abuse. It was revealed that out of 12,447 children, 53% reported sexual abuse and 21% suffered from severe forms of sexual abuse including rape, sodomy, fondling or exposure to pornographic material. This implies that every fifth child was facing severe forms of sexual abuse, and every second child across the country was being subjected to other forms of sexual abuse (Behere & Mulmule, 2013). Highlighting the vulnerability of younger children, it was reported that the abuse gained momentum at age of 10 and peaked between the age of 12 and 15 years (MWCD, 2007). Refuting high estimates of CSA amongst girls, the MWCD study revealed high incidence of sexual abuse among boys. 52% boys and 47% girls reported some form of sexual abuse in the study, with severe form of sexual abuse being higher among boys than in girls. Other studies by the non-government and international organisations (NGOs & INGOs) estimated the prevalence of CSA in India between 42% - 47% (Tulir, 2006; UNICEF, 2014). 15% of these children reported serious form of contact sexual abuse including rape (Tulir, 2006). 15% - 31% children were found to be under the age of

10 when the abuse began (Virani, 2000), 10% have been reported facing sexual violence during 10-14 years of age while 30% were between 15-19 years of age (UNICEF, 2014). Consistent with the MWCD findings, Tulir (2006) reported higher abuse of boys (48%) than girls (39%).

Quoting data from Childline-India, Singh et al. (2014) reveal a very high incidence of CSA in India. They report that, "for every 155th minute, a child less than 16 years is raped; for every 13th hour, a child under 10; and one in every 10 children is sexually abused at any point of time" (p. 431). 12,363 cases of child rape were reported to the police during 2013 as compared to 8,541 in 2012, which accounts for an increase of 44.7% (National Crime Records Bureau, 2014).

Table 2.1: Summary of CSA Facts in India and the UK

CSA Facts: UK	CSA Facts: India
1 in 20 children have been sexually abused (Radford et al., 2011)	1 out of every 2 children in schools have faced sexual abuse (MWCD, 2007)
21% females and 11% males have experienced sexual abuse (CSA Sub-group, 2010).	52% boys and 47% girls reported some form of sexual abuse, with severe sexual abuse found to be higher among boys than girls (MWCD, 2007).
More than 90% of children were sexually abused by someone they knew (Radford et al., 2011).	In 50% of cases, the abuser was in a relationship of trust with the child (MWCD, 2005).
1 in 3 children did not disclose sexual abuse to anyone (Radford et al., 2011).	72% children did not disclose sexual abuse to anyone, and only 3% families reported it to the police (Tulir, 2006).
2,884 children subjected to child protection plans by mid-2014 for being at risk of significant harm from sexual abuse (NSPCC 2015a).	1 in every 3 rape victims is a child (Singh et al., 2014)
Every day 13 cases of CSA including online abuse were handled by the police in 2013 (McKim, 2014).	Police reports on child rape indicate increase of 44.7% within a year in 2013 (National Crime Records Bureau, 2014).
Statutory services are aware of approximately 1 in 800 cases (CSA Sub-group, 2010).	71% sexual assault cases go unreported (MWCD, 2007).

2.2.2.3 Prevalence of CSA: Analysis of Trends in India and the UK

It is evident from the aforementioned studies that the prevalence of CSA is quite high in India and the UK. The data available in the UK indicates higher prevalence in females than males, while the abuse of boys is reported to be higher in India as compared to girls. However, in absence of large scale nation-wide studies with comparable data, it is difficult to draw such conclusions. Consistent with the global studies (Barth et al., 2013; Stoltenborgh et al., 2011; Pereda et al., 2009b), lower prevalence rate of CSA in the UK among boys was attributed to the lack of disclosure, reporting and treatment access (Glaser & Wiseman, 2000). Similarly, lower reporting of CSA among girls in India is attributed to the issues of shame, guilt and protecting family honour that deter disclosure (Tulir, 2006). Stoltenborgh et al. (2011) in their analysis of the effect of level of economic development of a country on CSA prevalence, suggest that sexual abuse of boys was found to be higher in low-resource countries than in high-resource countries. However, the same was not found to be relevant to the prevalence of CSA in girls. The need for more research is indicated to explore and understand this relationship further.

Further, all studies reviewed consistently confirmed that the abuser is usually known to the child, while stranger abuse is usually reported to be a minority. In 50% cases in India, the abuser was in a relationship of trust with the child (MWCD, 2007) and more than 90% of children in the UK were sexually abused by someone they knew (Radford et al., 2011).

In both India and the UK, the available statistics are considered to be 'a tip of the iceberg' (Human Rights Watch, 2013; Singh et al. 2014; NSPCC, 2015a)'. Lack of representative data on prevalence is attributed to methodological limitation of the existing studies. For example, the sample size and methodology of existing studies in India including the MWCD and other small scale studies by NGOs are reported to be limited in scope, focusing more on actual incidence of abuse in the sample of children studied rather than a reflection of overall gravity and magnitude of CSA in India (Human Rights Watch, 2013; MWCD, 2007). More importantly, CSA is under-

identified and underreported. It is believed that statutory services in the UK are aware of approximately 1 in 800 cases (CSA Sub-group, 2010) and 71% of sexual assault cases in India go unreported (MWCD, 2007). NSPCC (2015a) reports that the problem of CSA is much larger than that is revealed through the official statistics in the UK, as majority of it is not reported, identified or prosecuted. 1 in 3 children in the UK do not disclose sexual abuse to anyone (Radford et al., 2011). Likewise in India, in a small-scale study, a vast majority of children (72%) did not disclose sexual abuse to anyone, while only 3% of the families reported it to the police (Tulir, 2006). CSA is shrouded by secrecy, silence, stigma, shame and self-blame, which is often considered to be the reason for its underreporting (Virani, 2000). It is a crime that is, more often than not, only witnessed by the abuser and the victim (NSPCC, 2015a). This is consistent with the global studies that report that only 50% of CSA is disclosed and it is even lower (about 2%) in cases of intrafamilial abuse; only 15% of cases are reported to the police, and only 5% of them are resolved in the court (Sánchez-Meca, Rosa-Alcázar, López-Soler, 2011). For those few who come forward and report their sexual abuse, it is argued that there is often a prolonged delay between the event(s) and the disclosure (Friedenberg et al., 2013). Allnock & Miller (2013) estimated that the time between the onset of the sexual abuse and disclosure takes on an average about 7.8 years. The delayed and avoided disclosure not only has an impact on incidence and prevalence estimates of CSA, but also affects the understanding of child survivors, incident characteristics, abuse sequelae and overall impact of sexual abuse on children and adolescents (Friedenberg et al., 2013). These also prove to be barriers to accessing therapeutic support as well as recovery from effects of CSA (Courtois, 1997). Hence, the need for protection, early identification, and early intervention has been recognised (CSA Sub-group, 2010). It is believed that reliable prevalence estimates of CSA are needed for health research worldwide in order to appropriately estimate the burden and accordingly allocate economic resources for services and interventions (Barth et al., 2013).

Finally, besides the challenges to disclosure discussed, an analysis of the number of cases being passed on to the police reflects an increase in reporting of CSA both in India and the UK over the past few years. This increase in reporting of CSA is

attributed to a few high profile cases in the UK, such as Jimmy Savile ("Jimmy Savile NHS abuse victims aged five to 75", 2014; Live Updates, 2012), which has led to willingness and confidence in adults to speak out on behalf of children (Jütte et al., 2014). Similarly in India, CSA is beginning to gain visibility (Iravani, 2011). It is believed that increasing protests over the past two years, such as in Nirbhaya case (Jones, 2012) have "awakened many Indians to the scale and prevalence of sexual violence in the country" (Human Rights Watch, 2013, p. 1). Concerns of institutional or in-care abuse including CSA both in Scotland and India have also emerged at the same time (ACHR, 2013; Human Rights Watch, 2013; Shaw, 2011).

The increase in reporting implies a greater number of children presumably would require support services including therapeutic interventions. Within this context of high prevalence of CSA as well as changing climate in India and the UK including increasing visibility and reporting, the timing of this study seems critical to explore the therapeutic interventions being practiced with child and adolescent survivors of CSA in both these countries. Appropriate and early therapeutic interventions can help prevent long-term difficulties in child and adolescent survivors.

2.2.3 Impact of CSA: Treatment Needs of Child and Adolescent Survivors

CSA is one of the most serious public health problems globally, in particular for children and young people (Lalor & McElvaney 2010; MacMillan, 1998). In 2012, it was estimated that CSA costs the UK £32bn a year in costs towards services for children, health, criminal justice and loss of productivity to society (Saied-Tessier, 2014).

Over the past two-three decades, many studies have examined the impact of CSA on its survivors. Short-term and long-term negative consequences of CSA on child and adolescent survivors have been confirmed (Paolucci et al., 2001; Ross & O'Carroll, 2004), affecting their daily functioning (Giglio, Wolfteich, Gabrenya, & Sohn, 2011). At a broader level, research spanning from the 1980s to the present indicate that CSA impacts the survivors in multiple domains including physical, behavioural, psychological, cognitive, and social. Some of these domains include, but are not

limited to, interpersonal and social difficulties, academic difficulties, sexualisation, mortality, psychological symptoms and disorders such as post-traumatic stress disorder (PTSD), suicidal tendencies, and overall low sense of self and poor quality of life (Briere, & Runtz, 1993; Browne, & Finkelhor, 1986; Burgess, Welner, & Willis, 2010; Carr, 2006; Kendall-Tackett, Williams and Finkelhor, 1993; Nelson, 2009; Paolucci et al., 2001; Putnam, 2003; Read, Hammersley, & Rudegeair, 2007; Segal, 2009; Seshadri, 2002; Silverman, Reinherz, & Giaconia,1996). Carr (2006) suggests that about two-thirds of children who experience sexual abuse develop psychological symptoms; a fifth of cases show clinically significant long-term problems persisting into adult life; and about a quarter of cases develop more severe problems. Silverman et al. (1996) in their long-term study found that 80% of young adult survivors of CSA met the diagnostic criteria for at least one psychiatric disorder by the age of 21. Compared with non-abused participants, Silverman et al. (1996) reported that survivors demonstrated overall poor functioning and significant impairments at ages 15 and 21 including depressive symptoms, anxiety, psychiatric disorders, emotional difficulties, behavioural problems and suicidal ideation and attempts. Specific gendered impact on survivors was also noted (Silverman et al., 1996), however it is not seen to be consistent across studies (Paolucci et al., 2001). Approximately 55% children referred for treatment reveal comorbid psychological difficulties (Harvey & Taylor, 2010).

Figure 2.1**,** adapted from various studies discussed above, summarises the diverse impact that CSA may have on child and adolescent survivors.

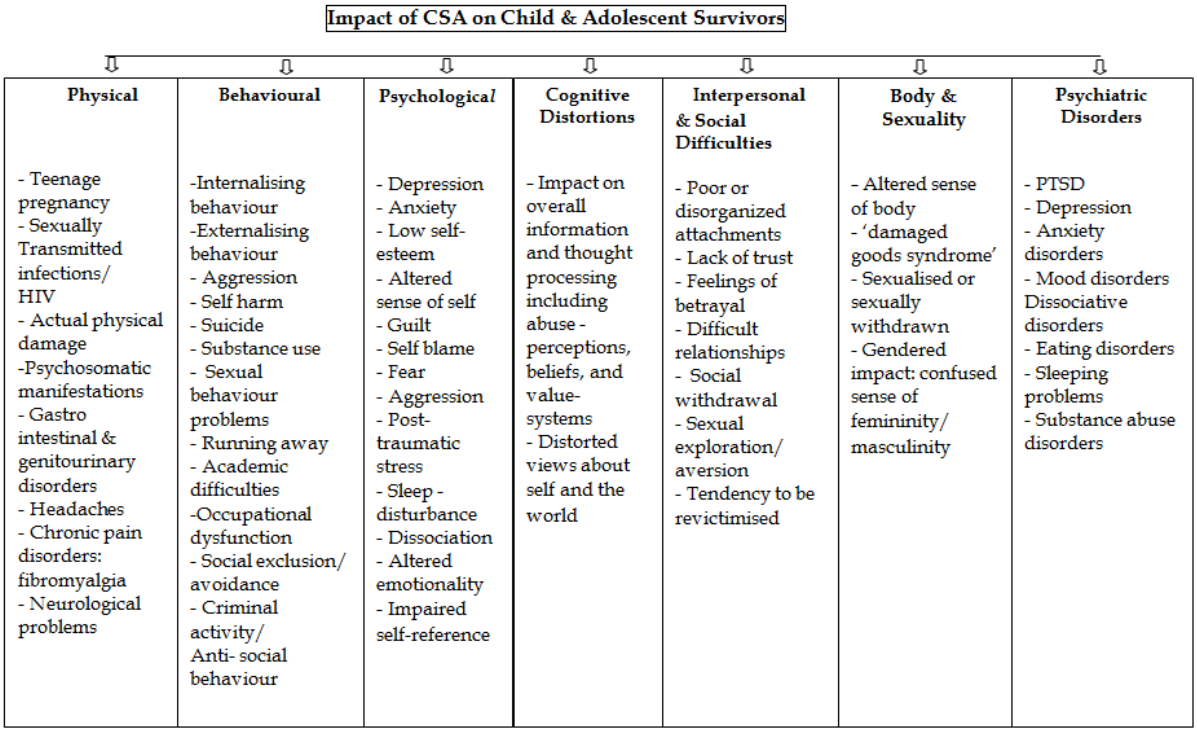

Figure 2.1 Impact of CSA on Children and Adolescents

However, it is noted that there is no specific 'CSA syndrome' or 'post-abuse syndrome' (Kendall-Tackett et al., 1993; Mullen & Fleming et al., 1998). Children may display a variety of symptoms but no single symptom may be displayed by majority of child survivors (Coren et al., 2009; Green, 1993). It is reported approximately about one-third of survivors do not show any symptoms and some symptoms are specific to certain ages (Kendall-Tackett et al., 1993). Some children may be affected much later in life, referred to as sleeper effect (Briere, 1992; Green, 1993; Macdonald et al., 2012; Putnam, 2003). Further, CSA survivors are also known to be prone to sexual revictimisation (Lalor & McElvaney, 2010; Trowell et al., 2002). The variation in the impact of CSA in children and adolescents is found to be mediated by various factors. These include, but not limited to, characteristics of abuse experience (duration and frequency of abuse, proximity to the perpetrator); negative internalisations and attributions about self and the world (including shame and self-blame), negative coping patterns, and interpersonal difficulties including insecure attachments (Kendall-Tackett et al., 1993; Feiring, Taska, & Chen, 2002; Whiffen & Macintosh, 2005). The impact of CSA is variable, complex and multifaceted, which makes the survivors of CSA a heterogeneous group with varied

needs and presentations for therapeutic support and intervention (Cohen, 2008; Mullen & Fleming, 1998)

Overall, more studies are concluding that children with sexual abuse trauma suffer from higher physical and psychological difficulties and symptoms than those who are not sexually abused (Briere & Runtz, 1993; Kendall-Tackett et al., 1993; Saied-Tessier, 2014) as well as those with other non-sexual forms of traumatic experience (Palo & Gilbert, 2015). Saied-Tessier (2014), based on the review of different studies (e.g. Andrews et al., 2004; Bebbington et al., 2008; Diaz et al., 2002; Hawton et al., 2002, cited in Saied-Tessier, 2014**),** report depression, and suicide and self-harm to be two and three-times higher, respectively in sexually abused children compared with those with no sexual abuse experience.

Further, research reveals that almost half of female psychiatric inpatients, i.e. 48% (Read et al., 2007) and 50-75% of adult female patients including inpatient and outpatient settings (Courtois, 1997) have histories of sexual abuse in childhood. Survivors of intrafamilial CSA are found to be overrepresented in a number of other at-risk populations such as the homeless, women in prison, prostitution, and substance misuse (Courtois, 1997). Among women and men survivors of CSA, an increase in suicide attempts have been found compared with those without a history of sexual abuse in childhood (Clayton, 2004). This reveals the long term impact of CSA in adult life, reinforcing the need for early interventions with sexually abused children and adolescents to address the deficits created and minimise the risk of long-term adverse consequences (Silverman et al., 1996).

Finally, developmental stage and age of the child at the time of abuse determines the difficulties manifested and extent of long-term consequences experienced (Macdonald et al., 2012; Mullen & Fleming, 1998; Ross & O'Carroll, 2004). Sexual abuse during pre-pubertal stage of development is reported to be more traumatic, which is considered to be a critical period marked by numerous changes at different levels including physiological, psychological, intellectual, behavioural, cognitive and social (Mullen & Fleming, 1998). Sexual abuse at this stage leads to poor, insecure

or disorganised attachments due to fear, lack of trust and sense of betrayal in adult-child relationships (Cook et al., 2003). Further, studies also indicate that abuse in childhood affects brain formation leading to impaired development in children (Cook et al. 2003). Symptoms of anxiety, nightmares, sexually inappropriate behaviours and other externalising behaviours are reported to be more common in younger, pre-school children and school-aged children whereas depression, suicidal or self-harming behaviour and substance and or alcohol dependency may be more common among adolescents (Kendall-Tackett et al., 1993; Macdonald et al., 2012). Hence, a need for a developmental perspective has been emphasised to understand and address the impact and therapeutic needs of child and adolescent survivors (Macdonald et al., 2012; Mullen & Fleming, 1998). Adapting a developmental perspective would facilitate a better understanding of the developmental tasks that may have been affected and compromised due to CSA (Wieland, 1998).

At the same time, it has been considered useful to understand different types of abuse on children and assess effects of each so that specific therapeutic inputs can be provided to each. Polyvictimisation, i.e. multiple forms of traumatic and abusive experiences, is noted to be common in sexually abuse children including neglect, maltreatment, physical and emotional abuse, and/or other family problems. In addition, pathology including substance misuse, mental illness, witnessing violence, and other psychosocial stressors has also been reported (Courtois, 1997; Finklehor, Ormrod and Turner, 2007; Radford et al., 2011; Turner, Finkelhor, & Ormrod, 2010). Sexual abuse rarely occurs in isolation, which is partly considered responsible for heterogeneous nature of CSA (Parker & Turner, 2013). These factors do not only increase their vulnerability to CSA but raise the risks of higher mental health difficulties and disorders due to poor attachments, lack of care and parental strains (Trowell et al., 2002).

Hence, the impact of CSA is noted to be variable, complex and multifaceted, and varies with the developmental stage of the child, which makes the survivors of CSA a heterogeneous group with varied needs and presentations for therapeutic support and interventions (Berliner & Saunders, 1996; Cohen, 2008; Lalor & McElvaney,

2010; Mullen & Fleming, 1998). This heterogeneity and differential impact of CSA on children and adolescents makes it imperative to study the therapeutic interventions practiced by different professionals/therapists in order to address the same in different cultural and country contexts.

2.3 Therapeutic Interventions for Child and Adolescent Survivors of CSA

Therapeutic interventions for CSA are defined as "those interventions that intervene with children and young people or their families and carers, to reduce the longer term symptomatic impact of the experience of trauma resulting from sexual abuse" (Coren et al., 2009). Harvey & Taylor (2010) in their meta-analysis adopt a broader definition of therapy by Weisz, Weiss, Alicke, and Klotz (1987; p. 543), "any intervention designed to alleviate psychological distress, reduce maladaptive behaviour, or enhance adaptive behaviour through counselling, structured or unstructured interaction, a training programme, or a predetermined treatment".

Over the past three decades, a number of therapeutic interventions for the treatment of survivors of CSA are found in the extant literature (Avinger & Jones, 2007; Coren et al., 2009; Keller, Cicchinelli & Gardner, 1989; Malhotra & Biswas, 2005). These range from undocumented and poorly explained treatments within independent private practices to different theories, and therapeutic approaches and intervention models (Lev-Wiesel, 2008). The review of clinical literature including empirical studies on therapeutic interventions for child and adolescent survivors of CSA presents a number of complexities, challenges and gaps, which justifies the need for this study to explore the current therapeutic interventions followed by professionals in the 'real world' or 'actual practice'.

The key learnings from the review of literature regarding the therapeutic approaches for CSA therapy are summarised below.

2.3.1 Range of Therapeutic Interventions and Treatment Modalities with Varying Theoretical Constructs

A range of therapeutic interventions and treatment modalities for CSA are enumerated in literature (Allnock & Hynes, 2012; Cohen, Mannarino, & Knudsen, 2005; Finkelhor & Berliner, 1995**;** Lev-Wiesel, 2008; Misurell, Springer, & Tryon, 2011; Saunders et al., 2003). These vary in structure, content and impact, and are based on varying theoretical constructs (Cohen, Mannarino, & Deblinger, 2006; Lev-Wiesel, 2008; Reavey & Warner, 2001), such as psychoanalytic and psychodynamic theories, behavioural and cognitive behavioural, social learning, attachment, humanistic- such as person/child centred and gestalt (Nelson-Jones, 2011), developmental, and feminist (Avinger & Jones, 2007; Coren et al., 2009; Keller et al., 1989; Misurell et al., 2011; Reavey & Warner, 2001). Some of them seem to be mostly practiced with child and adolescent survivors such as play therapy, whereas others are used with both adults and child and adolescent survivors. The practice ranges from psychoeducation, screening, short-term abuse-focused therapy to more comprehensive long-term plans (Saywitz, Mannarino, Berliner, & Cohen, 2000) using different treatments modalities such as individual, family and group therapies practiced exclusively or in combination (Cohen et al., 2006; Dietz, Davis & Pennings, 2012; Lev-Wiesel, 2008; Tourigny, Hébert, Daigneault, & Simoneau, 2005).

2.3.2 Therapy Better Than No Treatment

Although treatment outcome studies are limited (Finkelhor & Berliner 1995; Ross & O'Carroll, 2004), a large consensus has been found in existing empirical studies suggesting therapy facilitates recovery for child and adolescent survivors of CSA and that it is better than no treatment and/or being on a wait-list (e.g. Finkelhor & Berliner 1995; Greenspan et al., 2013; Hetzel-Riggin et al., 2007; Lanktree & Briere, 1995; Passarela, Mendes, & Mari, 2010; Ross & O'Carroll, 2004; Sánchez-Meca et al., 2011; Skowron & Reinemann, 2005). The availability of large number of therapeutic approaches and models for sexual abuse survivors in itself is considered to be indicative of the benefits of therapy for alleviating symptoms and negative

sequelae associated with CSA (Berliner & Saunders, 1996). Therapy not only leads to improvement in post-traumatic and other psychological symptoms associated with CSA (Lanktree & Briere, 1995), but it also prevents development of future difficulties and symptomatology (Springer et al. 2012), as well as revictimisation and recidivism (Duffany & Panos, 2009). In a meta-analysis on effectiveness of psychological interventions for child maltreatment, including survivors of sexual abuse, Skowron and Reinemann (2005) reported significant improvements in 71% children who received therapy compared with those who received no treatment. Further they reported that treatment increased the improvement rate by 28% while children who were not offered therapy deteriorated over a two-year period (Springer et al., 2012). Studies that compared CSA-treatment outcomes with a controlled group of untreated survivors found outcomes to be positive for both boys and girls as well as for children with disabilities such as deafness (Sullivan, Scanlan, Brookhouser, Schulte, and Knutson, 1992). Therapy is also reported to be beneficial for non-offending or safe parents/carers (e.g. Cohen et al., 2006; Cohen & Mannarino, 1996, 1998; Deblinger, Lippman, & Steer, 1996; Deblinger, Steer, Lippman, 1999) as well as in improving relationship between them and the child survivor (Tourigny et al., 2005). In interfamilial abuse, if the perpetrator is one of the parents, the other parent is referred to as a non-offending or safe parent (Macdonald et al., 2012).

Given the evidence regarding severe and long-lasting risks associated with CSA and benefits of treatment for sexually abused children and adolescents, the significance of early intervention is vital (Greenspan et al., 2013; Lev-Weisel, 2008; Sánchez-Meca et al., 2011; Trask et al., 2011). It reinforces the need for identification and application of "most effective" treatment (Cohen, Deblinger, Mannarino, and Steer, 2004, p. 401).

2.3.3 Therapeutic Interventions: Limited Evidence-Base and Gaps in Knowledge and Practice

The benefits of therapy in facilitating recovery from CSA have been noted and a number of therapeutic interventions enumerated, however, significant benefits and

support for one treatment approach over the other have not been found (Coren et al., 2009; Finkelhor and Berliner; 1995; Harvey, & Taylor, 2010). This is because few interventions for child and adolescent survivors of CSA have been evaluated with a sound scientific rigour and methodology (Berliner & Saunders, 1996; Cohen et al., 2006; Cohen & Mannarino, 1996; Kazdin & Weisz, 1998; Misurell et al. 2011; Ross & O'Carroll, 2004; Skowron & Reinemann, 2005). Further, an absence of psychological conceptual framework for comprehending and treating abuse-related trauma symptoms and difficulties (Ross & O'Carroll, 2004) and lack of clear treatment protocols (Lev-Wiesel, 2008) has been reported. There is a lack of consensus on treatment characteristics (Hetzel-Riggin et al., 2007) and/or treatment guidelines for child and adolescent sexual abuse therapy (Hetzel-Riggin et al., 2007). Developing uniform guidelines for CSA-therapy is considered to be challenging due to the associated complexities and heterogeneity of CSA (Glaser, 1991; Glaser & Wiseman, 2000).

There has been a growing focus on providing evidence-based therapeutic interventions in all fields including social work, health care (Webb, 2001), and treatment for CSA survivors (Denton, Walsh, & Daniel, 2002; Jones & Ramchandani, 1999). Evidence-based practice has been described as "the selection of treatments for which there is some evidence of efficacy" (Denton et al., 2002, p. 40). Randomised Controlled Trails (RCTs) are considered to be the 'Gold Standard' for evidence-based treatment trials, which include randomly assigning selected participants to well-defined treatments, including an index treatment group compared with an alternative treatment or wait-list control group (Cohen et al., 2005; Cohen et al., 2004).

Overall empirical controlled studies on effectiveness of different therapeutic interventions with children and adolescents in general, and CSA survivors specifically, are reported to be limited (Allnock & Hynes, 2012; Ramchandani & Jones, 2003; Saywitz et al, 2000; Misurell et al., 2011; Springer et al., 2012). Although some researchers posit that there is an increase in empirical evaluation studies over the past decade (Cohen et al., 2004), these have been found to be limited

to cognitive-behavioural therapy (CBT) and trauma-focussed CBT (TF-CBT). Other psychotherapy approaches, including psychodynamic therapy, family therapy, child-centred therapy, play therapy, or other structured group treatment modalities have not been well evaluated (Cohen, 2008; Lev-Wiesel, 2008; Saunders et al., 2003). CBT/TF-CBT are considered to be studied frequently in efficacy studies as they are shorter in duration and easy to manualise, standardise and use in structured, controlled treatment trials (Coren et al., 2009; Saywitz et al., 2000) such as RCTs.

Following trends have been noted regarding different therapeutic approaches based on the review of literature including empirical studies.

2.3.3.1 Effectiveness of Therapeutic Approaches: Inconclusive Evidence

Due to higher number of empirical studies on CBT and TF-CBT compared to other therapy approaches, these seem to be the most effective interventions for child and adolescent survivors of CSA at the first instance (Greenspan et al., 2013; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; Ramchandani & Jones, 2003; King et al., 1999). However, these claims are not sustained when other reviews are analysed.

2.3.3.1.1 Evidence-Base: CBT, TF-CBT and other Structured Approaches

Although limited, existing individual RCT studies on CBT-based approaches emphasise their effectiveness in improving a wide range of trauma symptoms in young children who have experienced sexual abuse. These studies include CBT in general (Deblinger et al., 1996, 1999; King et al., 2000); CBT for sexually abused pre-school children (CBT-SAP/Cohen & Mannarino, 1996, 1997); Sexual-abuse specific CBT (SAS-CBT/Cohen & Mannarino, 1998); and TF-CBT (Cohen et al., 2004; Cohen et al., 2005; Deblinger, Mannarino, Cohen, & Steer, 2006; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). Most of these approaches have been developed and evaluated by the researchers themselves. CBT and TF-CBT were found to be superior and statistically

significant in alleviating symptoms associated with CSA compared with other controlled treatment conditions such as non-directive supportive therapy (Cohen & Mannarino, 1996, 1997, 1998; Cohen et al., 2005), child-centred therapy (Cohen et al., 2004; 2006); standard community care (Deblinger et al., 1996, 1999) and wait-list control condition. These were also reported to be efficient in reducing PTSD symptoms as quickly as possible (Deblinger et al., 2006) with sustained improvements over 3 month, 6 months, one and two years periods after treatment completion (Cohen & Mannarino, 1996, 1997; Cohen et al., 2005; Deblinger et al., 1996, 1999, 2006; Mannarino et al., 2012). Few of these studies also report the efficacy of CBT with pre-school or very young children, aged 2-6 years (Cohen & Mannarino, 1996, 1997; Deblinger et al., 2011; Deblinger, Stauffer, & Steer, 2001). Cohen & Mannarino (1996) found behavioural interventions better for pre-school children than play therapy, especially for sexually inappropriate behaviours. The effectiveness of CBT for reducing PTSD symptoms in sexually abused children was also confirmed in a systematic review (Passarela et al., 2010). Furthermore, all of the above studies also included non-offending parents and caregivers. All these studies found greater improvement in parents assigned to CBT or TF-CBT specifically for relieving abuse-specific distress, increasing support for the child, and overall parenting practices. However, significant differences in the efficacy of CBT for children with or without parental engagement were not found (Deblinger et al., 1996, 1999; King et al., 2000). Other non-RCT, pre and post treatment design studies on structured cognitive and behavioural based approaches report similar improvements in children and non-offending parents/caregivers post-treatment and at 1-2 year follow up. These include stress inoculation and exposure treatment (Berliner & Saunders, 1996) and relatively newer treatments such as group-based CBT (GB-CBT/Misurell et al., 2011; Springer et al., 2012). Based on the evidence of effectiveness of TF-CBT, it is also clinically accepted for treating the sequelae of CSA including PTSD in children and adolescents. For example, the National Institute for Health and Care Excellence (NICE), UK recommends TF-CBT for adults as well as children and young people with PTSD, which includes CSA as one of the causal factors (NICE, 2005).

However, researchers caution against accepting conclusions regarding the effectiveness of CBT just because it is frequently evaluated, and consider it as one of the challenges of evaluating the evidence-base for psychotherapy (Carr, 2006; Lalor & McElvaney, 2010). This caution seems to be legitimate, as evidence contrary to the above studies has been reported.

The results on the effectiveness of CBT were not found to be statistically significant in two meta-analyses (Macdonald et al., 2012; Macdonald, Higgins & Ramchandani, 2006). Both these meta-analyses reported moderate effects in the areas of PTSD and anxiety symptoms reduction for which CBT has been considered to be highly effective in most individual studies. The need for more carefully conducted and better-reported trials on CBT have been suggested in these meta-analyses. Other reviews echo these findings. The evidence in favour of CBT is considered to be "more equivocal than some reviewers would suggest, including those who have themselves conducted trials" (Parker & Turner, 2013, p. 4). Consistent with the findings of Macdonald et al. (2012, 2006), other meta-reviews and meta-analysis that compared CBT with different treatment approaches, indicated that the evidence for effectiveness of CBT is less robust than had been previously assumed and it may not be useful for all children and adolescents (Coren et al., 2009; Saunders et al., 2003). Even one of studies that reported the effectiveness of TF-CBT indicated clinical concerns about its structured and relatively fast-pace nature that may overwhelm some sub-groups of children (Deblinger et al., 2006). Effectiveness of CBT for younger children has also been questioned (Greenspan et al., 2013). Further, there are differences between CBT and TF-CBT as therapeutic approaches, with a trauma narrative component or gradual exposure to the traumatic experience being central to the latter and absent in former. However, it is unclear which of these two approaches is more effective than the other (Greenspan et al., 2013).

At the same time, effectiveness of other structured therapeutic approaches for CSA-therapy has been reported, although studies were found to be limited. For example, a study that compared effectiveness of CBT with Eye Movement Desensitisation and Reprocessing (EMDR) with sexually abused girls in Iran (Jaberghaderi et al., 2004)

found positive outcomes with both these approaches for PTSD & behaviour problems. On the contrary, EMDR was considered more efficient i.e. in achieving these outcomes in less time compared with CBT. In a pilot study, Weiner, Schneider, and Lyons (2009) found TF-CBT, child-parent psychotherapy and structured psychotherapy equally effective in improving traumatic stress symptoms, behavioural and emotional needs, and child's strengths across racial groups (including white, African-American, Hispanic and biracial populations) of children exposed to trauma. These studies also point towards cultural relevance of these therapies.

2.3.3.1.2 Evidence-Base: Non-Directive Approaches

RCTs of other treatment approaches and models are reported to be rare (Cohen et al., 2004) or completely non-existent. However, researchers suggest several therapeutic approaches include "significant therapeutic components that may contribute to therapeutic change above and beyond TF-CBT" (Misurell et al. 2011, p. 16), and have been considered to be effective for improving symptomatology associated with CSA in children and adolescent (Greenspan et al., 2013). In this section, studies identified on different non-directive therapeutic approaches including psychodynamic therapy, play therapy, art therapy, and animal assisted therapy have been discussed.

No RCTs were found on psychoanalytic/psychodynamic psychotherapy in the recent review by Parker and Turner (2013). Referring to it as a treatment of choice for many health professionals, they emphasise that an absence of RCTs "does not mean that the intervention (psychodynamic) does not work in this population" (p. 12) referring to child and adolescent survivors of CSA. Two active comparison design studies on the psychodynamic therapy (psychodynamic compared with Behavioural Reinforcement Therapy by Downing, Jenkins, & Fisher, 1988; & brief focussed psychoanalytic individual therapy compared with psychoeducational group therapy by Trowell et al., 2002) found it effective, particularly for reducing PTSD symptoms and increasing adaptive functioning. Even though the sample size was small,

Trowell et al. reported the effectiveness of psychodynamic therapy with female survivors of multiple traumas in addition to CSA including repetitive sexual abuse, multiple perpetrators and severe family dysfunction. Similarly, in a meta-analysis, humanistic therapies including client-centred therapy (CCT) have been considered to be as effective as CBT for child and adolescent survivors of CSA with sustained improvements found up to one year after treatment completion (Elliott, 2002).

Play therapy has received similar positive reviews. Greenspan et al. (2013), in a recent review, report that most studies supported the efficacy of Play Therapy. Although studies on play therapy for CSA are reported to be sparse (Scott, Burlingame, Starling, Porter, & Lilly, 2003), there is support for its use, especially in combination with other therapeutic approaches. For example, CCT has been shown to be effective in play therapy by Scott et al. (2003) and they reported an increase in sense of competency of children over time and during play therapy. Based on the review of literature, Springer et al. (2012) emphasise integrating play therapy techniques with other evidence-based treatment for CSA**.** Sánchez-Meca et al. (2011) also posit that the best results were found when TF-CBT was combined with supportive and a psychodynamic element, such as play therapy.

Other approaches such as art therapy (Pifalo, 2002; Pretorius & Pfeifer, 2010), drama therapy (Mackay, Gold, & Gold, 1987), and animal assisted therapies (AAT) including equine-assisted therapy (Eggiman, 2006) and use of therapy dogs (Dietz et al., 2012; Reichert, 1994, 1998) have also showed positive results in active comparison studies for reducing symptoms and overall helping children recover from CSA trauma, however recommendations for structured empirical studies were emphasised. Besides providing symptomatic relief, these therapies are considered to facilitate disclosure of CSA by providing a child-friendly, safe and comforting therapeutic space (Eggiman, 2006; Reichert, 1994), however AAT is not considered to be appropriate for all children (Dietz et al., 2012).

2.3.3.1.3 Systematic Reviews and Meta-Analyses on Multiple Psychological Therapies

Besides individual studies discussed above, some systematic reviews and meta-analyses have examined the effectiveness of multiple psychological therapies or a range of psychotherapeutic approaches for CSA (though limited in number) with children and adolescents. These include a few meta-analyses (Cohen, Mannarino, Murray, & Igelman, 2006; Benuto & O'Donohue, 2015; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Sánchez-Meca et al., 2011; Skowron and Reinemann, 2005; Trask et al., 2011) as well as meta/systematic reviews (Coren et al., 2009; Finkelhor & Berliner, 1995; Greenspan et al., 2013; Jones & Ramchandani, 1999; O'Donohue, & Elliott, 1992; Saunders et al., 2003; Ross & O'Carroll, 2004) and other studies (New York City Alliance against Sexual Assault; NYCAASA, 2005). The therapeutic interventions reviewed included narrative therapy, play therapy, family therapy, CBT (including family CBT, child CBT, trauma focussed CBT, group CBT), EMDR, child centred therapy, image rehearsal therapy, stress inoculation training, and supportive counselling/therapy, abuse specific treatment, art or drama therapy and no treatment. A combination of treatment modalities have also been studied (individual, family, group or mixed/combination). Broader inclusion criteria, beyond presenting and measurable symptoms, have been applied including variables such as behaviour problems, psychological distress, social functioning, self-esteem, self-concept, coping skills and adaptation. One study also examined approaches in various settings such as research, agency, government or combination (Harvey & Taylor, 2010). These approaches included have not always been mutually exclusive, for example cognitive behaviour, abuse focussed, group therapy may be used together (Cohen et al., 2004).

All of the above meta-analyses and reviews conclude that therapeutic intervention is better than no treatment, however definite efficacy or superiority of any treatment method over the other has not been demonstrated. Reduction in symptoms of distress and psychological disturbance associated with CSA was found in the majority of studies following treatment irrespective of the therapeutic approach studied (Arvinger & Jones, 2007; Coren et al., 2009; Greenspan et al., 2013; Harvey &

Taylor, 2010; O'Donohue & Elliott, 1992; Ross & O'Carroll, 2004; Skowron & Reinemann, 2005). Some researchers conclude that no therapeutic intervention exclusively or in combination with another intervention can be considered as a "gold standard treatment (p.233)" for the range of symptoms associated with CSA for children and adolescents (Greenspan et al., 2013). Some multi-therapy studies found different approaches useful for specific outcomes. For example, eclectic and play therapy is reported to be most effective for social functioning difficulties (Hetzel-Riggin et al., 2007; Benuto & O'Donohue, 2015); abuse- specific, supportive therapy and group therapy for behaviour problems (Hetzel-Riggin et al., 2007); cognitive-behavioural and individual therapy for reducing psychological distress including anxiety, depression, behavioural problems and PTSD in children and adolescents (Hetzel-Riggin et al., 2007; King et al., 2002; Passarela et al., 2010); art therapy and individual supportive therapy for facilitating emotional expression related to CSA (Sánchez-Meca et al., 2011); and CCT for treating problems related to self-esteem, self-concept and symptoms of depression (Scott et al., 2003). Supportive and directive approaches are preferred by some over the non-directive treatments as the silence involved in the latter is considered to cause avoidance replicating the silence of the abusive experience (Ross and O'Carrol, 2004).

Hence, it is suggested that the choice of therapy should depend on the child's main presenting secondary problem (Hetzel-Riggin et al., 2007). Practice of integrative approach, i.e. combinations of different therapies, is recommended in this regard (Greenspan et al., 2013). Some studies recommend involvement of non-offending parent(s)/cares as beneficial (e.g. Harvey and Taylor, 2010), while others have not found added advantage of engaging them together with the child in therapy (Corcoran & Pillai, 2008; Passarela et al., 2010; Trask et al., 2011).

2.3.3.1.4 Pharmacological Treatment

Although no studies have been reported comparing pharmacological treatment with therapeutic interventions (NICE, 2005; Passarela et al., 2010), the evidence-base for drug treatment in PTSD, including when caused due to CSA, is indicated to be

limited (Cohen, Scheid, & Gerson, 2014; NICE, 2005). No such studies were found in this review as well.

2.3.3.1.5 Other Trauma Models for CSA-Therapy and Complex Trauma

Other non-RCT, pre and post treatment design studies on models developed specifically for rape, sexual assault or complex trauma for children and adolescents report similar improvements in children and non-offending parents/caregivers post-treatment and at 1-2 year follow up. For example, Recovering from Abuse Programme, which is a structured experimental treatment programme based on Traumagenic Dynamic Model (Finkelhor & Browne, 1985); the Attachment, Self-Regulation, and Competency framework (ARC) for complex trauma (Arvidson et al., 2011; Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2005); and Integrated Treatment of Complex Trauma for Children (ITCT-C; Lanktree & Briere, 2008, 2013) and Adolescents (ITCT-A; Briere & Lanktree, 2008; 2013). In addition to these, other diverse therapeutic models for CSA-therapy with children and adolescents are documented in literature but lack empirical evidence. Some examples include the Trauma Model (Herman, 1992), Resolution Model (Orenchuk-Tomiuk, Matthey & Christensen, 1990), and Internalisation Model (Wieland, 1997, 1998). These models primarily suggest a stage-wise, sequenced and integrated approach with slight variations in all. However, not much information about the outcomes and evaluation of these models is available in literature. Further, mindfulness and meditation based models for people with histories of child abuse have also been highlighted, however most of them seem to have been practiced and evaluated with adult survivors (Earley et al., 2014; Hill, Vernig, Lee, Brown, & Orsillo, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010).

Hence, it is evident from the above review that a wide range of therapeutic approaches are enumerated in literature ranging from traditional, well known approaches to newer, less known models. However, the evidence of effectiveness of these approaches and models for CSA therapy with children and adolescents is inconclusive, and rather contradictory and controversial. Little is known about the

actual practice of these in applied, clinical settings. Most studies recommend further research to examine specific benefits of different approaches and whether or not particular approaches lead to better outcomes (e.g. Harvey & Taylor, 2010). Drawing conclusions about the effectiveness of therapeutic approaches in absence of comparison treatment groups is considered to be challenging (Greenspan et al., 2013). At the same time, it is acknowledged that no treatment programme is perfect and there may be side effects associated with therapy for some children, such as worsening of symptoms, irrespective of the approach followed (Berliner & Saunders, 1996).

2.3.3.2 Effectiveness of Therapeutic Modalities: Inconclusive Evidence

There is lack of consensus also on the effectiveness of any one therapeutic modality over the other, including one-on-one or individual therapy, group therapy and family therapy for CSA with child and adolescent survivors. In a recent meta-analysis, it is recognised that the effectiveness or superior treatment gains of individual, family, or group modality still need to be ascertained (Benuto & O'Donohue, 2015). Similar to the therapeutic approaches, the evidence for these treatment modalities is inconclusive and inconsistent (Ramchandani & Jones, 2003).

Frequent use of these modalities has been reported either exclusively or in combination (Lev-Wiesel, 2008). Few studies have specifically focussed on effectiveness of different therapy modalities, including group, individual and family therapy in a combination of therapeutic approaches (such as CBT, psychodrama, CCT, psychodynamic and unspecified models). These include independent studies (e.g. Duffany & Panos, 2009; Gorey, Richter, Snider, 2001; Nolan et al., 2002; Liotta, Springer, Misurell, Block-Lerner, & Brandwein, 2015, Tourigny et al., 2005), meta-analyses (Reeker, Ensing, & Elliott, 1997), and a systematic review (Avinger & Jones, 2007).

Few researchers report family-based and individual approaches to be more effective for trauma symptoms than group therapy (Harvey and Taylor, 2010). On the other

hand, some studies support group modality as more effective than individual therapy for sexually abused children and adolescents (Avinger and Jones, 2007; Duffany & Panos, 2009; Gorey et al., 2001; Reeker et al., 1997) and non-offending mothers (Duffany & Panos, 2009). For example, Dietz et al. (2012) found AAT to be more effective in group settings. Similarly studies on CBT in groups (Deblinger et al., 2001) including a new approach introduced, GB-CBT (Misurell et al., 2011; Springer et al., 2012) report its greater benefits in group settings. Some consider group therapy to be a "frequently chosen method of intervention for child sexual abuse survivors" (Dietz et al., 2012, p.666) due to its benefits associated with peer support and feedback (Dietz et al., 2012), cost-effectiveness (Reeker et al., 1997; Tourigny et al., 2005; Misurellet al., 2011; Springer et al., 2012) and for preventing revicimisation and recidivism (Duffany & Panos, 2009). Overall, outcome research on group therapy modality has been considered to be sparse and unreliable (Avinger and Jones, 2007; Duffany & Panos, 2009).

Similar to therapeutic approaches, some researchers did not find a clear evidence of effectiveness or benefits of one modality over the other (Greenspan et al., 2013; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Nolan et al., 2002). Both individual and group therapy, practiced exclusively or in combination, have been reported to be equally effective in the treatment of the psychological sequelae of CSA, without clear statistical differences between the two regardless of the study design (Greenspan et al., 2013; Gorey et al., 2001; Nolan et al., 2002; Trask et al., 2011; Trowell et al., 2002) even at a follow up of 6 months or more (Nolan et al., 2002). Similarly, clear evidence of effectiveness of family therapy is also missing. Hetzel-Riggin et al. (2007) found low effect sizes for family therapy, which they report as being inconsistent with previous findings.

Overall, it can be concluded that there is some support for each modality including, individual, group and family, irrespective of the psychotherapeutic approach practiced (Jones and Ramchandani, 1999). All modalities have been found to be associated with positive changes (Skowron & Reinemann, 2005). Some recommend

individual or group therapy to be used according to the age, and/or reactions of the survivors to the CSA-trauma experienced (Greenspan et al., 2013).

2.3.3.3 Length of Treatment: Inconclusive Evidence

Concerns have also been raised about appropriate length of the treatment and ways of standardising the same (Greenspan et al., 2013). Some studies including meta-analysis (Corcoran & Pillai, 2008; Hetzel-Riggin et al, 2007; Sánchez-Meca et al., 2011; Trask et al., 2011) and individual studies by treatment developers (e.g. Lanktree & Briere, 2013) report greater improvements in child and adolescent survivors with longer duration of therapy. On the contrary, treatments achieving symptomatic relief or outcomes quicker are considered to be more efficient, as it shortens the suffering of the child from symptoms and risks associated with CSA (Cohen et al., 2005). However, due to lack of consensus, it is considered crucial to ascertain appropriate length of the treatment (Benuto, & O'Donohue, 2015) as well as effectiveness of "briefer, more intensive forms of therapy" compared with "a longer-term, but less intensive, form of therapy" (Greenspan et al., 2013, p. 237). Researchers have also emphasised the need to examine the influence of a setting or facility on the practice of a therapeutic interventions as well as the length of treatment (Greenspan et al., 2013).

2.3.3.4 Overall Critique of Existing Empirical Studies: Limited Scope and Methodological Flaws

Overall, a number of limitations of existing empirical studies have been reported that make it challenging to draw conclusions about effectiveness of therapeutic approaches for children with diverse needs and backgrounds.

2.3.3.4.1 Limited Scope: Overemphasis on Symptomatology and Lack of Developmental Perspective

One of the key critiques of the existing studies on therapeutic approaches for CSA therapy with children and adolescents including RCTs and other study designs is that most of these are situated within the symptomatology or PTSD framework (King et

al., 1999; Ross and O'Caroll, 2004). Overall, the scope of interventions documented in the literature is reported to be limited, usually targeting fear, anxiety, low-mood and sexually inappropriate behaviour (Macdonald et al., 2006). The studies are based on clinical samples of symptomatic CSA survivors who complete the treatment (Lalor & McElvaney, 2010). Further, it is reported that therapeutic interventions that are considered to be effective for CSA in existing studies, such as the cognitive behavioural approaches, were primarily developed for the treatment of post-traumatic stress symptoms caused due to different forms of traumatic episodes (Lev-Weisel, 2008), and not specifically for CSA. Hence, the focus of these interventions and their evidence-base seems to be strongest for PTSD-symptoms reduction (Macdonald et al., 2012).

PTSD is characterised by development of key symptoms following exposure to an extreme traumatic event (which includes sexual assault), such as flashbacks, dreams or nightmares, sense of numbness, emotional blunting, detachment from other people, unresponsiveness to surroundings, avoidance of activities and situations reminiscent of the trauma (American Psychiatric Association; APA, 2000). PTSD is one of the outcomes associated with CSA in some children. 30-50% of sexually abused children meet partial or full criteria for post-traumatic stress disorder (Cohen, 2008; Kendall-Tackett et al., 1993; Maikovich, Koenen, & Jaffee, 2009).

However, PTSD has been critiqued as an adult-centred conceptualisation being applied to children and adolescents (Cook et al., 2003; Mullen & Fleming, 1998). "Most current conceptualisations of childhood PTSD are some distance away from a genuinely developmental approach" (Pat-Horenczyk, Rabinowitz, Rice, & Tucker-Levin (2009, p.62). The diagnostic criteria for PTSD is not considered sensitive to developmental factors and cannot explain the impact of prolonged or repeated abuse such as intrafamilial sexual abuse during different child and adolescent development stages (Connor & Higgins, 2008a, 2008b; Cook et al., 2003; Courtois, 2004; Herman, 1992; Mullen & Fleming, 1998). Further, it is difficult to measure PTSD symptoms in child and adolescent survivors as, available instruments are reported to be of limited use with children (Cohen et al., 2008; Saywitz et al., 2000). Another

key challenge in application of the PTSD model to children is regarding the difficulty in ascertaining pre-trauma functioning in children (Foa & Meadows, 1997). It is argued that a significant feature of PTSD is that the symptoms represent a change from pre-trauma functioning, which is difficult to ascertain in childhood abuse survivors as many of them have not known a life without trauma (Foa & Meadows, 1997). The need for clearly inferring the degree to which these symptoms represent PTSD is highlighted before applying treatments recommended for PTSD. Overall, it is recognised that vulnerabilities and social situations associated with multiple traumatic experiences for children and young people require greater attention, management and interventions (Ramchandani and Jones, 2003).

Herman (1992) distinguished between PTSD caused due to an exposure to a single traumatic event and complex PTSD (C-PTSD) that is caused due to multiple traumatic experiences across childhood and adulthood. Children and adolescents exposed to multiple traumas (e.g. prolonged, repeated CSA, polyvictimisation, and or other forms of prolonged social and interpersonal traumatic events) by one or more persons particularly within the care-giving system seem to be understood better within the complex trauma framework. The complex trauma conceptualisation is informed by the developmental framework of children and adolescents, and encapsulates the dual problem of children's exposure to multiple traumatic events as well as the immediate and long-term impact of trauma exposure. Its impact is noted on all areas of child's development, divided in seven key domains: attachment; emotional regulation; cognition and learning; biology; dissociation; behavioural regulation and control; and self-concept (Cook et al., 2003). Other models of understanding the impact of CSA in different domains beyond focusing on symptoms have also been proposed, for example the traumagenic dynamics (Finkelhor, 1987; Glaser, 1991).

Further, it has been established earlier that the age at the time of abuse determines the extent of long-term consequences for survivors. Hence, it is suggested that the child's age at the time of abuse must be taken into consideration in therapy in order to understand the developmental tasks that may have been affected and compromised

(Wieland, 1998). At the same time, it is useful to assess different types of abuse on children and effects of each so that specific therapeutic inputs can be provided to each. The developmental perspectives provides models of dynamic interaction and risk factors that make the child vulnerable while also highlighting the significance of child's strengths, resilience and protective factors that can be enhanced through early intervention and therapeutic support (Mullen & Fleming, 1998). Further, the trauma and subsequent recovery overlaps with normal developmental processes in survivors of child abuse, hence adjunct techniques, such as education about normal interpersonal interactions are recommended (Foa & Meadows, 1997). Addressing developmental needs and issues of children in recovery is considered significant (Seshadri, 2002).

Considering the previous diagnostic and statistical manual (APA, 2000) guidelines did not appropriately address these complexities and the developmental impact of trauma on children and adolescents, a new diagnosis, 'developmental trauma disorder' has been introduced in DSM-V (APA, 2013). This includes sexual assault and is considered more appropriate for intrafamilial, early, chronic and multiple experiences of trauma (Greenspan et al., 2013; Sar, 2011). Difficulty in establishing a diagnosis is considered another challenge in comparing treatment approaches for child and adolescent survivors of CSA (Greenspan et al., 2013).

However, the aforementioned complexities are not reflected in most empirical studies that have assessed the treatment outcomes and effectiveness of various therapeutic approaches for CSA (Cohen, 2008*).* Gender, age and development stage have not been adequately considered for treatment design (Harvey & Taylor, 2010). Age-specific therapeutic interventions have been found to be lacking in literature, and lack of focus of benefits and effectiveness of different treatments depending upon the age at the time of sexual abuse has been acknowledged (Greenspan et al., 2013). Children and adolescents have been included as part of the same sample in most studies, although trauma impact and adaptation to treatments may vary significantly for them as they are at different developmental phases (Passarela et al., 2010).

Further, concerns have also been raised about exclusion of diverse groups of children from existing empirical studies. These include asymptomatic child and adolescent CSA survivors, those who self-harm or cause harm to others (Berliner & Saunders, 1996; Lalor & McElvaney, 2010), and those who do not disclose and/or withdraw their claims of CSA (Lalor & McElvaney, 2010). Early intervention is suggested for all child survivors depending on their needs, situation and presentations including those who are symptomatic, asymptomatic or those who do not appear severely distressed (Berliner & Saunders, 1996; Colangelo, 2012). However, these complexities of CSA survivors are not captured in existing studies. Due to lack of studies, effective treatments for such children are not known including the impact of CSA on them, their therapeutic needs, as well as effectiveness and practice of therapeutic interventions with them (Lalor & McElvaney, 2010; Lev-Wiesel, 2008).

Lack of details and clarity in the existing studies about the abuse characteristics including nature and frequency of sexual abuse, age of onset and time since abuse, and relationship to perpetrator has also been critiqued (Harvey & Taylor, 2010; Sánchez-Meca et al., 2011). Lack of complete information regarding abuse characteristics also limits the scope of assessing effectiveness of interventions as it makes it difficult to draw conclusions about moderators of treatment (Harvey & Taylor, 2010).

2.3.3.4.2 Methodological Flaws, Geographic and Demographic Limitations

Additionally, poor quality of existing studies with an array of methodological flaws and inconsistencies in most of the studies make it difficult to generalise findings or draw robust conclusions about effectiveness of different treatment interventions. This critique has been reported regarding a majority of studies including controlled/RCT studies on CBT and TF-CBT (Macdonald et al., 2006, 2012), quasi-experimental or other study designs on different psychotherapies (Benuto & O'Donohue, 2015; Lalor & McElvaney, 2010; Sánchez-Meca et al., 2011), and treatment modalities such as group interventions (Nolan et al., 2002; O'Donohue & Elliot, 1992; Duffany &

Panos, 2009). Comparing results between different studies is challenging due to the considerable variation in the specific outcomes measured (Greenspan et al., 2013; Benuto & O'Donohue, 2015; Macdonald et al., 2006, 2012). Further, details in existing studies about methodological strengths and limitations are lacking (Ross and O'Carroll, 2004).

Challenges with the process of evaluating the evidence-base itself are emphasised. RCTs are considered to be the gold standard in research for identifying the evidence-based interventions. However, the most recent review and synthesis of meta-analyses on treatment of sexually abused children identified only 23 RCTs (approximately 29%) out of the 77 studies, included from seven meta-analyses reviewed (Benuto & O'Donohue, 2015). The need to tailor treatment specific to each child's response to sexual trauma experienced has been identified as a challenge in conducting RCTs with sexually abused children.

Further, most of the existing studies on different treatment interventions originate from the USA (Harvey & Taylor, 2010; Macdonald, 2006, 2012). The majority of the studies in a meta-analysis by Sánchez-Meca et al. (2011) were identified from North America (41 of the 51 groups), followed by Europe (5 groups), Oceania (3 groups), and least from Asia (2 groups). A number of studies have been conducted only with girls and in quite a few of them, gender has not been revealed (Macdonald, 2006, 2012). In addition, the existing studies lack demographic details about the participants including ethnicity and socio-economic status (Harvey & Taylor, 2010; Sánchez-Meca et al., 2011). These limitations pose the challenges regarding replications of the studies and generalising the findings to different contextual, cultural and gender groups. A need for accessible and culturally sensitive treatment options has been recognised as these factors are considered significant in determining the recovery of children following CSA (Coren et al., 2009). However, little is known about treatment responses for CSA survivors specific to different cultural, racial, ethnic and religious identities, and need for further research in this area has been identified (Lalor & McElvaney, 2010; Saunders et al., 2003; Springer et al., 2012). One study (Jaberghaderi et al., 2004) that compared EMDR and CBT

treatment with sexually abused girls in Iran concluded that structured treatments can be applied to children in Iran. Similarly, Weiner et al. (2009) found the cultural relevance of therapies in their pilot studies and they emphasised the need for flexible adaptations of treatment approaches to the construct of cultural competence. However such studies of cultural relevance are limited. Even in these studies, small sample size was considered to be a limitation in drawing firm conclusions and a need for adding cultural assessment to evaluation protocols was emphasised.

2.3.4 Conclusions: Practice and Effectiveness of Therapeutic Approaches

To conclude, this literature review has illustrated that evidence regarding the effectiveness of current therapeutic approach and modality is weak and contradictory. A range of treatment approaches with varying constructs pose challenges in drawing conclusions about their outcomes (Avinger & Jones, 2007). At the same time, considering that a number of therapeutic approaches have demonstrated improvement in symptoms indicates that symptom alleviation is not entirely dependent on the type of treatment received (Greenspan et al., 2013). Some researchers attribute the variations in treatment outcomes across studies to the heterogeneity of CSA including interplay of diverse variables in abusive experience and therapeutic practices (Hetzel-Riggin et al., 2007; Reeker et al., 1997). For example, variations in specific group treatments, age of survivors, abuse characteristics (i.e. the type, severity and length of abuse and the relationship of the child to the perpetrator), and child characteristics and circumstances (such as the vulnerability and resiliency of the individual child and the reaction and support of the family). Hence, a need for multiple theories and therapeutic interventions specific to each child's needs and circumstances is emphasised (Ross, & O'Carroll, 2004). Stating that 'no one size fits all', some studies conclude with a recommendation for diverse, individualised/tailor- made, client specific, multimodal treatment and/or sequence and stage based approaches at different times in life depending on the developmental stage of child and adolescent survivors (Cohen, 2008; Coren et al., 2009; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Saunders et. al., 2003).

Research on most of the therapeutic approaches for child and adolescent survivors of CSA either does not exist or is in its infancy, fragmented and affected with methodological flaws. Greater research is required to evaluate the benefits, efficiency and effectiveness of therapeutic interventions including cost-effectiveness of one treatment compared with another (House, 2006; Macdonald et al., 2006; 2012). A greater need for information to guide therapy practice with CSA survivors has been identified (O'Donohue & Elliott, 1992).

2.4 Rationale of the Study

Despite the multiplicity of programmes, including generalist clinicians and hundreds of specialised CSA treatment programmes (Finkelhor & Berliner, 1995), there is lack of information on practice of these interventions by professionals in the field. Although, widespread use of different interventions is reported, it is acknowledged that there is lack of research on how the treatments are effectively assigned to survivors of CSA (Lev-Weisel, 2008; Saunders et al., 2003). Although a large body of clinical theory and expertise on interventions for CSA exists at present, researchers posit "theory and practice sometimes vary greatly" (Finkelhor & Berliner, 1995, p. 1414). Due to limited empirical studies that inform practice (Cohen & Mannarino, 1996) and absence of a clear evidence-base, conceptual framework and/or treatment protocols, there is a concern that the "case management decisions and decisions about what techniques to be used in treatment are made by clinicians without empirically tested guidelines" (Lev-Weisel, p. 671). Further, it is recognised that the range of therapeutic interventions and expertise within communities of practice is not reliably represented in the existing research and empirical studies with child and adolescent survivors of CSA (Coren et al., 2009).

It is evident from the above review of extant literature that the effectiveness of treatments currently used with child and adolescent survivors of CSA remains largely unaddressed and inconclusive. Additionally, there is a concern that most of the theoretical constructs and interventions documented do not provide sufficient guides to therapy for this population (Reavey & Warner, 2001). Further, not much is

known about the therapeutic interventions practiced by the professionals in real/applied, clinical settings'. Lastly, the key aim of the evidence-based framework is to ensure that the practice is informed by "research evidence" or is "grounded in evidence" (Webb, 2001, p.59; Warwick-Booth, Cross, & Lowcock, 2012). It is unclear what informs the therapeutic practice with child and adolescent survivors of CSA considering the absence of culturally-specific, clear guides to therapy for this population and inconclusive, rather conflicting and contradictory, evidence-base in all areas including the type of treatment for different forms of CSA-trauma (single episode vs. complex, multiple trauma), therapeutic modality (individual vs. group therapy), and length and duration of therapy (long-term vs. short term). These gaps prompted the motivation to undertake this study with professionals in different settings (statuary, voluntary sector and private practice) to explore therapeutic approaches practiced by them with child and adolescent survivors, and what factors govern their choice of a particular approach or model. Over the past two decades, a need for engaging in a dialogue with professionals regarding their practice and theory, as well as conducting observational studies in the real world settings has been emphasised (Finkelhor & Berliner, 1995; Macdonald et al., 2012). Exploring lived clinical realities by involving practitioners is also considered a way of ensuring culturally attuned research (Dallos & Vetere, 2005).

A number of factors prompted the focus of the study on psychotherapy specifically for child and adolescent survivors. These included researcher's personal and professional interest in child protection and well-being. As mentioned previously, the researcher has worked on issues of CSA and human trafficking for sexual exploitation for a number of years, with a focus on child and adolescent survivors. Gaps in therapeutic services for these survivors were experienced while working with them in India. Further, the need for early identification and intervention in order to address short-term impacts and prevent long-term negative consequences motivated the researcher to undertake this study, with a focus on child and adolescent survivors.

2.4.1 Geographic Relevance of the Study: India and the UK

A motivation to understand culturally-specific practice of therapeutic interventions with child and adolescent survivors of CSA prompted me to position this study in two culturally, socially and economically diverse countries. The gaps identified in the practice of therapeutic interventions in India due to my professional work experience as well as the lack of studies on therapeutic interventions or treatment for CSA survivors in India were the initial motivating factors to undertake this study. In addition, a number of similarities and differences in the field of CSA in particular and child protection in general, in India and the UK, prompted the selection of these two countries for the study.

As signatories to the UNCRC, both India and the UK are committed to take measures to protect children from violence and maltreatment, and promote physical and psychological recovery and social reintegration of child survivors. Specifically with regards to CSA, its high prevalence as well as under-reporting and lack of disclosure have been acknowledged in both these countries. Further, lack of adequate treatment and therapeutic support for children and adolescents who disclose CSA is reported both in India and the UK (CSA sub-group, 2010; Deb & Mukherjee, 2011). Given that most of the empirical studies have been conducted in the US, there is a lack of knowledge about the culturally-specific therapeutic practice for CSA, especially regarding the choice of approaches and models in actual settings/services, both in India and the UK. However, the UK is relatively advanced in mental health policies, systems and services in general, and specifically in practice of therapeutic interventions for CSA survivors compared with India (Sharan & Sagar, 2007).

2.4.1.1 The Study Context: India

In India, very few studies have been conducted on psychological and physical outcomes of CSA for survivors in general and particularly focusing on children and adolescents. No studies are known to be conducted on interventions developed or implemented with survivors including children and adolescents (Jain, Vythilingamn,

Eapen, & Reddy, 1992; Malhotra & Biswas, 2005). Professionals and researchers have lagged behind in documenting, reporting or researching intervention for CSA survivors and an urgent need for research in this area has been emphasised (Malhotra & Biswas, 2005). Further, in developing countries such as India, policies, systems and specialised mental health services and interventions in general and specific to CSA are lacking (Sharan & Sagar, 2007). Although Child Protection Bill, 2005 and policies such as Integrated Child Protection Scheme (MWCD, 2009) have been developed in India, child protection services have not been introduced, and a lack of appropriate professionals to provide psychological and medical services to sexually abused children has been reported (Deb & Mukherjee, 2011). Even in POCSO 2012, which is a new and quite a comprehensive legislation for sexual assault offences against children, there is a lack of provision for mental health and psychological support and interventions for its survivors. The first Mental Health Policy in India was launched recently in 2014 (Ministry of Health & Family Welfare, 2014; TNN, 2014).

Overall, mental health and psychological service provision in India is quite limited (Sharan & Sagar, 2007), particularly for child (and adult) survivors of trauma including CSA. "India has a strong presence of non-governmental bodies, networks, community-based organisations, civic forums and peoples' campaigns" (Saini, 2013, p. 304), and have played a lead role in the care and acceptance of the mentally ill and the distressed (Patel & Thara, 2003, p. 1). Few services that are available for mental health intervention in India are mostly based in hospitals or other custodial settings, which are limited in approach and practice (Sharan & Sagar, 2007). The same service provision applies for the survivors of CSA. Professionals from medical, social and psychological fields have not integrated the interventions for CSA survivors in a holistic manner (Malhotra & Biswas, 2005). Most of the therapeutic models and approaches have not been developed, tested and/or practiced with survivors of CSA in India, and there is no known culturally-relevant intervention developed or implemented for CSA-therapy for children and adolescents in India (Sharan & Sagar, 2007; Jain et al., 1992).

To the best of the knowledge of the researcher, this is a first study being conducted in India on exploring therapeutic interventions for child and adolescent survivors of CSA.

2.4.1.2 The Study Context: UK

Although empirical studies about the effectiveness and practice of therapeutic interventions in the UK are also lacking, considerable progress has been made with respect to legislations, policies, strategies and services for child protection and mental well-being in general as well as for child and adolescent survivors of CSA. Some examples include the Children Act, 2004; Sexual Offenses Act, 2003; Her Majesty's (HM) Government (2010) guide to inter-agency working to safeguard and promote the welfare of children, and the National Mental Health Strategy (HM Government, 2011, 2012; Scottish Government, 2012). There has been a special focus for overall well-being of children and adolescents, which is reflected in the national mental health strategies and their implementation frameworks as well as child-specific policies such as Every Child Matters (Department for Education and Skills; DfES, 2003) and Getting it Right for Every Child (Scottish Government, 2008). A focus on survivors of CSA is also apparent through the Survivor Scotland Strategy for Adult Survivors of Childhood Sexual Abuse (Survivor Scotland, 2005), although a similar strategy or policy for children and adolescents is missing. The implementation of the Strategy is monitored by the Scottish Parliament's Cross Party Group (CPG) for Adult Survivors of Childhood Sexual Abuse. A focus on implementation of evidence-based approaches is emphasised (Webb, 2011), which is apparent through the NICE guidance for PTSD that includes sexual abuse trauma with specific treatment recommendations for both children and adults. Further, Improving Access to Psychological Therapies (IAPT) programme was established in the UK in 2006, which is a central theme of the mental health strategy, both for adults and children and adolescents (Department of Health; DH, 2011a). This emphasises the government's commitment to ensure treatment access for children and young people by extending greater choice in Psychological Therapies including session times, venues and providers. This also ensures that service providers conduct

staff training in approved therapy modalities and make provisions for delivery arrangements to offer choice of treatment to service users (DH, 2011a).

Therapy service provision for child and adolescent survivors of CSA is quite different in India and the UK, which was another important motivation to study therapeutic approaches for CSA practiced in the UK. Besides the legislative and policy advancement, UK has a provision for CSA-Specialist services, both within statuary and voluntary sector services. Child and Adolescent Mental Health Services (CAMHS) are the NHS-provided statuary services, which includes CSA-Specialist services as part of Tier 3 of its services (NHS Choices, 2012). India does not have such statuary CSA-Specialist agencies.

CAMHS is divided into four tiers, which includes Universal Services and Generic/Targeted Services and Specialist Services. These tiers are explained in the Figure 2.1 below (Integrated Care Pathways for Mental Health; ICP, 2010; CAMHS Tier 4 Steering Group, 2014). These mental health services are considered to be community-based as they are based within the community rather than in hospitals. The professionals in the Tier 1 service, referred to as 'Universal Services' comprises of professionals from multiple agencies and disciplines such as the general practitioners (GP), health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. This is the primary tier where children with mental health difficulties are referred first by parents and carers. These professional or service providers are skilled to provide general advice and treatment for less severe problems. They provide referrals to other specialist CAHMS services (Tier 2-4) if a need for the same is recognised. Tiers 2-4 are considered 'Specialist Services' with qualified and trained mental health professionals. Tier 2 services are also referred to as 'Generic or Targeted Services' and cater to children and young people with milder problems. Tier 3 comprises 'Specialist Services' with multidisciplinary teams of child and adolescent mental health professionals for children and young people with more severe, complex and persistent difficulties and disorders. Tier 4 include day and inpatient services and some highly specialist outpatient services and

comprise of multidisciplinary mental health professionals as the Tier 3 (ICP, 2010; CAMHS Tier 4 Steering Group, 2014).

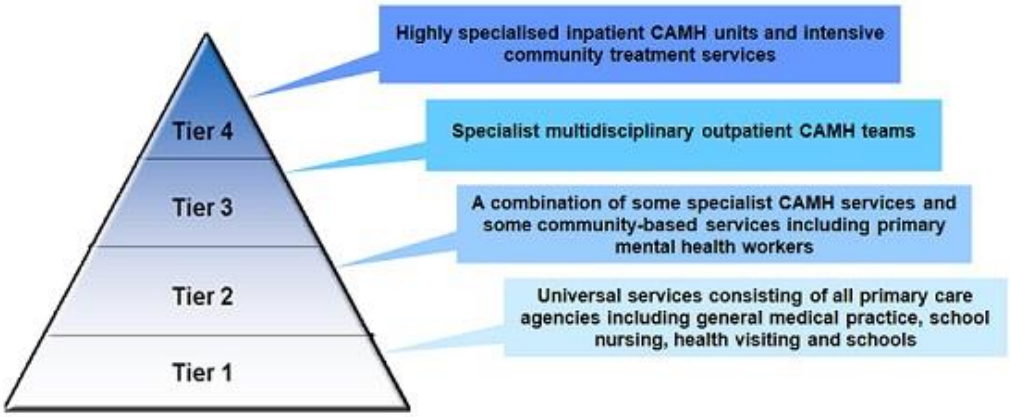

Figure 2.2: Child and Adolescent Mental Health Services, UK (ICP, 2010)

The statuary 'CSA Specialist' services are part of Tier 3, which are constituted of trained, multi-disciplinary teams including child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, and art, music and drama therapists (ICP, 2010). Multi-agency service provision is considered to be integral to the CAMHS (DCSF, 2010b). The CSA-Specialist teams work closely with the Universal services (Tier 1), which implies that supporting and protecting children and young people with mental health difficulties is not the responsibility of specialist services alone (DCSF, 2010b).

Besides the CAMHS, there are voluntary organisations providing similar specialist CSA- therapeutic support to children and their families in the UK.

2.5 Conclusions

The actual practice of therapeutic approaches and models with sexually abused children and adolescents in different service settings in India and the UK is unclear, given a variety of issues such as high prevalence rates of CSA, complexity in treatment with diverse and heterogeneous group of CSA survivors, vast body of approaches and models documented in literature with limited evidence-base, and lack of research in this area in both these countries. India and the UK are culturally, socially and economically diverse, with clear differences in therapeutic service provision with respect to CSA-therapy for children and adolescents as well as the level of priority and significance accorded to children and their overall well-being and protection. The UK is more advanced in mental health policies, strategies, systems and services than India, with a system of CSA-Specialist therapeutic services as well as a high emphasis on evidence-based practice.

By examining the practice of therapeutic interventions with child and adolescent survivors of CSA in India and the UK that have similarities in the trends of CSA but diversity in therapeutic service provision and policies, the research would contribute to a better understanding of a range of evidence-based approaches available and adopted in 'real or actual practice settings'. This wider understanding would enable the development of culturally-specific theoretical model of approaches to CSA therapy with children and adolescents based on the practice followed by varied professionals in the field.

Michaud et al. (2001) estimated that by 2020, psychological trauma will be among the leading causes of disability, alongside depression and heart disease (cited in Karatzias et al., 2011). Therefore, it is a key requirement of time that appropriate, early intervention strategies to mitigate psychological trauma in children and adolescents are documented and implemented. Within this context, this study is of great relevance within India and the UK, considering the complex psychological trauma experienced by child and adolescent survivors of CSA.

Chapter Three

Methodology

"A Psychology that involved a move towards qualitative methodology would be more in keeping with contemporary definition of what science is and what it can achieve."

(Smith, 1996; p.191)

3.1 Introduction

In this chapter, research methodology adopted for the study is described including the research design, and use of constructivist grounded theory (CGT) for data collection, analysis and construction of the theoretical model of practice guideline for CSA-therapy. In the first part, rationale for choosing a qualitative research design and CGT approach for this study has been explained. This is followed by detailed explanation of the recruitment process, data collection, management and analysis in the second part. Finally, in the third part, reflexivity and issues of ethics and quality of the study have been addressed.

3.2. Research Design

The process of choosing the most appropriate methodology, design and methods should be governed by research questions or research problem (Charmaz, 2006; Warwick-Booth et al., 2012). Based on the research questions and overall aim of the research to develop a culturally relevant theoretical model of approaches to therapy with child and adolescents survivors of CSA, a qualitative research design following constructivist grounded theory method was selected for the study.

3.2.1. Qualitative Research

Qualitative inquiry in research has a long history and is used routinely in a number of disciplines including psychology and health studies (Warwick-Booth et al., 2012).

Qualitative research is suitable for studies that seek to understand the "experiences, actions and events as they are interpreted through the eyes of particular participants, researchers and (sub)cultures" (Henwood, 1996, p. 27). Qualitative paradigms are labelled as 'interpretative', 'contextual' and 'naturalistic' (Henwood, 1996) as they seek to capture the complexities of behaviour and meanings in their natural contexts, based on the philosophical assumption that reality is constructed by the social world in which people live (Warwick-Booth et al., 2012). The emphasis of qualitative researchers is on understanding the social, situational and structural contexts in which data is generated and the influence of researchers on this process is considered significant; whereas the quantitative research is considered to be multivariate and weak on context, with researcher being distant and an outsider (Warwick-Booth et al., 2012). Hence, qualitative methods are suggested to be important in inquiry about people's experiences and processes within their context as well as meaning people make of their experiences, which cannot be captured through quantitative methodology (Patton, 2002).

A qualitative design was considered to be best suited for this study considering its key aim and research questions. It was envisaged to be a naturalistic and exploratory study to gain an in-depth understanding of CSA-therapy with child and adolescent survivors as practiced by professionals in two different countries within their specific cultural and structural or service contexts. It was considered essential to capture the essence, perspectives and rationale of the professionals vis-à-vis their therapeutic practice with child and adolescent survivors of CSA in their 'real world' or 'natural' settings. Qualitative methods are considered to be best suited when it is critical to explore the phenomenon, meanings, and experiences of individuals in its natural form, as it is the case in this study.

Further, a qualitative study is considered suitable for exploring issues and developing conceptual models where there is lack of previous research (Patton, 2002). The research in the area of therapeutic interventions for CSA, both in terms of efficacy studies and actual practice in the field, is considered to be in its infancy. Little is known about the actual therapeutic practice with children and adolescents who are

sexually abused both in India and the UK. A qualitative design adopted in this study would expand the scope of the current (yet limited) studies on therapeutic approaches for CSA, which are largely treatment outcome and/or efficacy studies based on quantitative designs including RCT, quasi-experimental and pre/post-test designs and assess changes in measurable symptoms and difficulties associated with CSA. Most of them fail to provide the context, complexities and variations in practice of different professionals and factors or 'their realities' or experiences that prompt them to choose a therapeutic approach over the other. Wiser, Goldfried, Raue, Vakoch (1996) highlight such tensions between practice and research in psychotherapy, and argue that "researchers and clinicians live in vastly different worlds" (p. 101). They postulate that clinicians consider psychotherapy research simplified due to the methodological constraints and not directly relevant to what is being done in practice. On the contrary, practitioners are condemned by researchers for their lack of application of the learning from research literature into their practice. Considering these limitations in the existing research, this study was designed to enter the 'world of the clinicians (practitioners of psychotherapy)' to gain a better understanding of their practice experience in CSA-therapy and to inform current CSA-psychotherapy research by the views, learnings and experiences of the practitioners.

Qualitative research is a broad term that comprises an array of research methodologies governed by different philosophical positions, techniques and procedures (Creswell, 2007; Creswell, Hanson, Plano, & Morales, 2007). In the following section, rationale for the choice of Constructivist Grounded Theory qualitative research methodology for the study is discussed.

3.2.2. Grounded Theory

The research aim primarily prompted selection of Grounded Theory (GT) methodology for the study, in addition to its rigorous and scientific approach to qualitative research. The aim of the study was to develop a culturally relevant theoretical model of approaches to CSA-therapy with child and adolescent survivors based on the data generated. A qualitative methodology that would aid development

of such a theoretical explanation or model based on the analysis of participants' responses had to be selected. GT method seemed most appropriate for achieving this aim.

GT was developed by Glaser and Strauss as an inductive methodology for generating new theory from data in opposition to high emphasis at the time upon the deductive verification and testing of extant theory against data (Glaser and Strauss, 1967). They shifted the focus of research from 'theory verification' to 'theory generation'. Grounded in the symbolic interactionism perspective, it aims to illuminate the social processes of interaction (Charmaz, 2006; Bluff, 2005) through the interplay of significant gestures, symbols and systems of meaning embedded within a critical social context (Pidgeon, 1996). Over the years, it has evolved based on different philosophical underpinnings (Mills, Bonner, & Francis, 2006a).

GT has become a popular and widely used method in health care and psychology as it provides rich foundation for qualitative research (Pidgeon, 1996). GT methodology has been adopted in a number of studies in health care and psychology (Morrow & Smith, 1995; Parker, 2011; Rennie, 2001). It is considered to be popular as it provides researchers the tools to analyse qualitative data in a more rigorous way while giving them some freedom to decide the direction of their analysis and enables in creation of theoretical constructs, statements or explanation during empirical investigation (Konecki, 2011). It allows the researcher to begin inquiry from the research participants' point of view and facilities crucial examination of subjectivity of experience (Tweed & Charmaz, 2012).

Further, GT can be used where existing theories or areas of research are under-defined, under-explored or patchy (Strauss and Corbin, 1998; Tweed & Charmaz, 2012). It has the flexibility and sensitivity to be responsive to changing contexts and conditions (Tweed & Charmaz, 2012), which was considered relevant for this study as it was set out to explore CSA therapeutic practice of professionals based in two different countries (India and the UK) and various practice settings (e.g. statuary, voluntary sector and private practice). Further, in qualitative research, GT inquiry

helps in generating a framework – a theory, explanation or a theoretical model - of a process, action or interaction based on the data collected reflecting views and experiences of the participants (Strauss & Corbin, 1998). GT helps to 'generate' or 'discover' a theory or a theoretical construct or framework grounded in data from the participants who have experienced the process (Glaser & Strauss, 1967; Creswell, 2007). Hence, I adopted a GT approach to qualitative research with the aim to construct a meaningful account and theoretical conceptualisation that integrates the variations and complexities of participants' worlds (Henwood, 1996) with respect to the therapeutic practice in India and the UK with child and adolescent survivors of CSA.

3.2.3 Constructivist Grounded Theory

From among different versions of GT approach (Charmaz, 2006; Glaser and Strauss, 1967; Strauss & Corbin, 1990; 1998), the research design including data collection and analysis was guided by a Constructivist Grounded Theory (CGT) approach (Charmaz, 2006). Besides the research aims and questions, the epistemological stance governs the choice of a research method (Henwood, 1996). A combination of these considerations that informed the selection of CGT qualitative research methodology for the study are discussed.

CGT is popular in qualitative research as it provides a scope for rich in-depth data collection as well as rigorous analysis and creation of theoretical constructs during empirical investigation (Konecki 2011). Consistent with the overall principles of GT (Glaser and Strauss, 1967), CGT enables the researcher to examine processes, patterns and meanings (Charmaz, 2006; Tweed & Charmaz, 2012) embedded in participants' responses. At the same time, Charmaz's approach is considered to be less structured and more adaptable (Creswell 2007). It provides scope for systematic, yet flexible, guidelines and structure in collecting and analysing data to construct theory from the data itself (Charmaz, 2006).

However, variation in the philosophical underpinning of CGT from the classic GT (Glaser and Strauss, 1967) and consequent differences in approach to data collection and theory generation prompted its selection as the overarching methodology for the study. These philosophical underpinnings of CGT are reflected in the positioning of the researcher in the study, development of the theory, and emphasis on reflexivity. While classic GT "plays down the creative role of the researcher in the research process" (Charmaz, 2008, p. 45), CGT stresses the involvement of the researcher during data collection and construction of the theory or concept from data (Dey, 1999, Charmaz, 2006). CGT recognises the multiple perspectives and subjectivities of the participants' world as well researchers' engagement in interpretive work for generating new understandings and theory (Pidgeon, 1996). The classic GT, governed by the positivist philosophy, emphasises "discovery of theory from data" (Glaser and Strauss, 1967, p.1) where "the researcher uncovers something that is already there" (Charmaz, 2008, p. 45). On the other hand, emphasising the collaborative role of the researcher, the CGT emphasises 'constructing' the theory, "through our (researcher's) past and present involvements and interactions with people, perspectives, and research practices" (Charmaz, 2006, p.10). Hence, CGT validates creativity of the researcher as an integral part of the inductive process followed in GT (Cutcliffe, 2000). These aspects of CGT were considered significant for the study due to my past involvement with the work on CSA as a practitioner in India. As established previously, my initial interest in this research was prompted by my practice experience in the field of CSA in India. Having worked with one of the pioneering voluntary organisations/NGO on CSA for eight years, I had familiarity with the overall field of CSA in India including most of the NGOs and some mental health professionals working in this area. A number of professionals engaged on CSA work, who were considered as potential participants for the study, knew me as a practitioner in this field and I had worked with them on collaborative CSA prevention and awareness campaigns in India. While past knowledge and experience is considered important in CGT and provides the theoretical sensitivity or points of departure for the study (Charmaz, 2006), CGT allows for the perspectives, views and priorities of the participants to be revealed without imposing preconceived notions of the researchers (Seale, Gobo, Gubrium, & Silverman, 2004). The emphasis in CGT

on reflexivity and documenting the research process throughout aids refection on researcher's preconceived notions (Charmaz, 2008, 2006) and guides in keeping "their own interpretive activity at bay until later stages of the analysis" (Dallos & Vetere, 2005, p.54).

To conclude, CGT methodology was adopted for the study as it provided the scope for open ended inductive inquiry into the therapeutic interventions practiced with child and adolescent survivors of CSA. It informed each step of the research design and analysis including forming open ended interview questions to conducting semi-structured in-depth interviews, simultaneously analysing data to code emerging categories and finally 'constructing' theoretical framework and/or guidelines for CSA-therapy with child and adolescent survivors of CSA.

3.3. The Procedure: Application of CGT

In this section, the application of CGT approach is detailed including, recruitment process, research settings, data collection methods, management and analysis. Data collection lasted from mid-2012- early 2014. The process of gaining access to participants took more time than expected including establishing initial contact with them through emails and receiving appointments for meeting and/or interviews. Further, data collection and analysis began simultaneously, hence interviews were spaced accordingly to account for transcription and analysis time in between.

3.3.1 Recruitment of Participants

3.3.1.1 Initial Recruitment of Participants: Purposive Sampling

The participants in India and the UK were initially recruited based on purposive sampling suggested in the GT approach, followed by theoretical sampling at later stages when codes and categories began to emerge (Tweed & Charmaz, 2012; Cutcliffe, 2000). "The purposive sampling technique, also called judgement

sampling, is the deliberate choice of an informant due to the qualities the informant possesses" (Tongco, 2007, p. 147). It is a classified as a "non-random technique" (p. 147) where underlying theories or a set number of participants are not required, as it is more important to find individuals who can provide the required information based on their knowledge or experience pertinent to the research questions of the study (Tongco, 2007).

Since the main research questions were to explore therapeutic approaches or models practiced by professionals with child and adolescent survivors of CSA and factors that influenced their choices, the main criteria established for recruitment was to engage professionals from different settings who provided therapeutic services for CSA to children and adolescents up to the age of 18 years. Although the recruitment criteria and procedure was largely the same in both India and the UK, there were some variations in the professionals, settings and way in which they were recruited. These variations have been indicated below and the details regarding total number of participants recruited from different settings for the study are provided in Table 3.1.

3.3.1.1.1 Recruitment of Professionals in the UK

Research Settings in the UK

It was found that majority of the therapeutic services to child and adolescent survivors in the UK are provided by two key sectors (Allnock et al., 2009; Health in Mind, 2011); hence, these two sectors were primarily focused upon within the UK:

- The statuary CSA-Specialist services of CAMHS: From among different generic and specialist services of CAMHS in the UK, specifically the CSA-Specialist services falling in Tier 3 were found pertinent to the study due to their key remit of providing therapy to children and adolescents who were sexually abused.

- The voluntary sector, with a specific focus and remit of providing therapeutic services to children and adolescents who were sexually abused.

With respect to the geographical spread, it was considered to recruit agencies/professionals based in Scotland and England. Allnock et al. (2009) in a study on service provision for sexually abused children and young people in the UK, found a gap in availability and accessibility of therapeutic services. For example, it is reported that out of 508 therapeutic services identified in their study, majority of them were based in England followed by Scotland, and only 4% were CSA-Specialist services. Hence, it was considered pragmatic to recruit professionals in both Scotland and England based on their willingness and availability. Further, given the limited number of CSA-Specialist services, concerns about anonymity were raised by few professionals in some services in Scotland during initial interaction for ascertaining their willingness to participate in the study. Expanding the recruitment process to include Scotland and England was also considered a way to ensure anonymity and confidentiality of the agencies and participants. Therefore, location of all the agencies is specified as UK rather than respective countries.

Identification and Recruitment of Participants in the UK

Extensive internet search was undertaken initially to identify potential participants for selection based on the criteria developed. Websites of different NHS boards in Scotland and England and web-directories of different voluntary organisations and networks were searched (e.g. Isurvive.org, 2012; The Survivors Trust, 2007-2012). A large number of voluntary organisations providing therapeutic services to adult survivors or adolescents (age 12 or 13 and above) were found but were not included based on the recruitment criteria of ensuring that children of all ages were included. A preliminary list of CSA-Specialist services and voluntary organisations (VO) was prepared through internet search, referrals received from the supervisors, and through participation in various meetings/seminars including meetings of the British Psychological Society Survivor Scotland and CPG on Adult Survivors of Sexual Abuse.

Initial contact was established through emails with managers of six CSA-Specialist services and three VOs (hereafter together referred to as agencies). A preliminary meeting was organised with the agencies based on the response received and their willingness to learn more about the study. These included three CSA-Specialist services and two VOs initially. A brief presentation was made to the teams of professionals in these agencies about the study in order to assess the interest of the professionals and seek participation of those interested for the study. An information sheet was prepared (Appendix 1) containing information about the purpose of the study, research aims and objectives, confidentiality, informed consent, voluntary participation and contact details of the researcher and primary supervisor. This sheet was provided to all members of the team inviting them to contact the researcher if they were willing to participate in the study.

At some agencies, few professionals present at the meeting agreed to participate readily. Appointments for interviews with three professionals from two CSA-Specialist services and one from a VO were received at the end of the meeting. The rest of the professionals from these agencies and others were contacted later at the stage of theoretical sampling as required. Hence, a total of four professionals were recruited at the initial stage from the UK based on purposive sampling.

3.3.1.1.2 Recruitment of Professionals in India

Research Settings in India

Participants in India were recruited from three settings based on the recruitment criteria developed. Due to my past involvement with this work in India, I was familiar with the work of some NGOs and a few mental health (MH) professionals (primarily psychiatrists). These MH professionals were either in private practice or largely associated with private hospitals in India and provided psychiatric and therapeutic services, including therapy to child and adolescent survivors of CSA. An additional list of other NGOs and departments in hospitals and mental health institutions providing psychological trauma or CSA-specific psychological services

was generated through internet search and snowball sampling. Snowball sampling, otherwise known as “chain referral sampling” (p. 141) is known to be a widely used method in qualitative research where the research participants are identified through referrals made by others who know of people possessing knowledge pertinent to the research interests (Biernacki & Waldorf, 1981). Snowballing is considered to be a useful approach in trying to access hard to find populations/samples (Warwick-Booth et al., 2012). Snowball sampling was helpful in recruitment of participants as it was difficult to identify professionals in hospitals and mental health institutions providing therapy to children and adolescents specifically for CSA.

Based on the internet search and interactions with different professionals, three key sectors were identified in India:

- NGO sector (VOs): These NGOs worked specifically on CSA issues and undertook a range of initiatives including preventive work. Counselling or therapeutic support to survivors was indicated as one of their initiative on websites of the identified NGOs. Most of them focused on sexual abuse experienced by children while a few catered to both child and adult survivors.

- Private practitioners: These included MH professionals in independent private practice or those associated with psychiatric wards/departments of private hospitals. Most of these were psychiatrists and some had a clinical psychologist associated with them.

- Professionals in MH institutions: These are institutions or hospitals specifically for MH well-being. These institutions had a range of MH professionals including psychiatrist, clinical psychologist, child psychotherapist and/or medical and psychiatric social workers.

Private practitioners, hospitals and mental health institutions provide generic mental health services for children and adolescents and most of them have multi-disciplinary

teams including mental health professionals such as psychiatrists and clinical psychologists, as well as social workers. Besides NGOs, the hospitals and MH institutions did not have CSA-specific services, although a few MH professionals in these settings were found to be associated with NGOs to provide CSA therapy. Only one of the mental health institutions was found to have a trauma recovery centre focusing on psychological trauma including child sexual abuse.

Identification and Recruitment of Participants in India

Email contact was initially established with some of the professionals I was familiar with in the NGOs and private hospitals. In addition, contact was established through phone and email with two professionals in one MH institution to seek participation in the study. An information sheet about the study was shared with all the professionals who were contacted. Three professionals agreed to participate in the study including one professional each from two NGOs and a professional from a MH institution. Professionals from different settings were selected from different states in India, however their respective locations have not been identified to ensure confidentiality and anonymity. Considering that only a few agencies working on CSA were found in India, with some states having only one organisation, it would be easy to identify the organisation even if their names are not mentioned.

A total of seven professionals (four from UK and three from India) were recruited and interviewed initially from different settings following purposive sampling. Informed written consent (Appendix 2) was obtained from each participant, confirming their participation in the study prior to the interview.

These interviews were transcribed and preliminarily analysed before recruiting further participants. This led to the generation of a range of codes and categories (discussed in detail later in the chapter), which set the stage for further interviews based on a theoretical sampling strategy. These initial recordings and/or transcripts as well as preliminary codes and categories were shared with the academic supervisors for examining their quality and discussing future directions and

sampling. After a preliminarily analysis of the initial seven interviews, I started further recruitment based on theoretical sampling.

3.3.1.2 Recruitment of the Participants: Theoretical Sampling

Theoretical sampling is considered to be a critical process in GT. It is defined as:

> "The process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses… data and decides what data to collect next and where to find them, in order to develop… theory as it emerges." (Glaser & Strauss, 1967, p.45).

Further, Charmaz (2006, p.101) explains theoretical sampling as:

> "purposeful sampling according to categories that one develops from one's analysis and these categories are not based upon quotas: they're based on theoretical concerns."

In GT, theoretical sampling is conducted to collect further data that would help in refining and developing the properties of emerging categories. Hence, it guides selection of the participants, sources of data as well as formulation of the questions used to collect data. This helps in developing theoretical focus on the emerging categories and its properties, leading to the construction of a theory (Lazenbatt & Elliott, 2005). This process of constant comparison of data generated through theoretical sampling is one of the integral and unique features of GT, where data collection and data analysis are conducted simultaneously. Thereby, categories and ideas developed are constantly refined through further data collection and inquiry, which ensures that the theory constructed is completely grounded in the data (Charmaz, 2006).

Following the GT approach, data analysis started parallel to the process of data collection. Codes and categories that began to emerge through the analysis of initial

seven interviews formed the basis for next step of theoretical sampling. Theoretical sampling guided the selection of participants, areas for further considerations, and interview questions and case narratives that were sought from the participants. The transcription and analysis was undertaken soon after each interview was conducted, and the emerging categories formed the basis for further questioning and inquiry in subsequent interviews.

Specifically, theoretical sampling included going back to different professionals in the same agencies where the initial interviews were conducted as well as identifying new agencies that could help in refining the emerging categories. For example, from the initial analysis of interviews conducted in the UK, categories such as 'organisational perspective and approach' and 'practitioner/therapist variations' were identified. To understand these categories in-depth and explore their properties in terms of variations in practice within the same agency, different professionals from the same agencies were selected for further interviews. These included lead clinicians or senior clinicians who had been with the agency for a number of years and could provide further information on the organisational choice of the therapeutic approach practiced. Besides, through interviews with other professionals, therapeutic approaches practiced by individual practitioners within the same agency were explored. Consequently two-four professionals from most agencies in the UK were interviewed to gain a better understanding of an approach practiced within the same setting or agency. It is suggested that maximum variation within theoretical sampling can be gained by taping and analysing each unit of the sample completely (Cutcliffe, 2000). To explore the above emerging categories, both the individual professionals interviewed as well as respective agency with which they were associated were considered to be independent units by itself during the stage of theoretical sampling to get a fuller picture of their practice of therapeutic interventions with child and adolescent survivors. Interviews with different professionals of the same agency helped me to understand individual variations in the same agency as well as the overall organisational stance or perspective as well as choice of a therapeutic approach.

Similarly, other categories emerged from the initial interviews in India, for example 'barriers to disclosure', 'barriers to providing therapeutic services', and 'social action interventions'. These began to reflect professionals' understanding of cultural factors in India that had an influence on the interventions practiced by them. To explore these categories further, focussed questions around these categories were included in subsequent interviews conducted with professionals in different agencies in India as well as in the UK. Further, professionals from additional agencies were recruited who were not thought of earlier during the initial stages of purposive sampling. For example, agencies working on CSA-issues with ethnic minority communities were identified and included to explore the aforementioned categories and other cultural factors or barriers that influenced therapeutic practices specific to these communities, which included the South Asian communities in the UK.

Hence, data sources and inquiry became specific to emerging categories as the data collection progressed. Following the theoretical sampling strategy, questions became more focused and targeted in subsequent interviews and/or new participants or agencies were selected that enabled in-depth exploration of emerging categories. Significant issues or categories that emerged from the analysis were continuously added to the interview guide, and were raised during the interview unless they came up spontaneously in conversation with the participants (Pidgeon & Henwood, 1996). This constant comparison through theoretical sampling is considered to be a self-correcting process as it helps in identifying the gaps in data and categories developed and directs further sampling accordingly (Charmaz, 2002). The sampling progressed in this manner until the developed categories were enriched and saturated (Charmaz, 2006; Strauss and Corbin, 1998).

3.3.1.3 The Final Sample

The final sample for the study included 32 participants from a total of 23 agencies from India and the UK. Table 3.1 presents the type and number of agencies recruited from India and the UK, and the total number of professionals recruited from different agencies is provided in Table 3.2.

Table 3.1: The Final Sample: Total Number of Agencies Recruited in India and the UK

Agency	India	UK	Total
CSA-Specialist Services	-	5	5
Voluntary Organisations	7	5	12
Private Hospital	1	-	1
Mental Health Institutions	2	-	2
Independent Practice (affiliated with NGOs)	3	-	3
Total	**13**	**10**	**23**

Table 3.2: The Final Sample: Total Number of Professionals Recruited from Different Agencies in India and the UK

Agency	India	UK	Total
CSA-Specialist Services	-	11	11
Voluntary Organisations	8	5	12
Private Hospital	3	-	3
Mental Health Institution 1	1	-	3
Mental Health Institution 2	1	-	1
Independent Practice (affiliated with NGOs)	3	-	3
Total	**16**	**16**	**32**

The sample included by and large all the identified NGOs and most of the MH professionals known to be working on CSA in India. The teams in CSA-Specialist services in the UK comprised a combination of various mental health professionals such as the clinical psychologists, community mental health nurses, art therapists, play therapists, occupational therapists, social workers, and psychiatrists. The teams in voluntary organisations in the UK as well as most of the agencies in India were not as diverse or multi-disciplinary. In India, most of the Founder Directors of the NGOs were recruited as they were the primary or only counsellors in the organisation. Some of them had undertaken training in some form of psychotherapy practice. The profile of each participant recruited in India and the UK is provided in Appendix 3 and 4 respectively.

3.3.2 Data Collection Tool: Intensive, In-depth Semi-Structured Interviews

Semi-structured, in-depth interviews were conducted with professionals. In many qualitative research studies in counselling and clinical research, interviews are one of the key methods of data collection. Most GT studies adopt semi-structured interviews as a key method of data collection as they allow interaction between researcher and participants focussing on key issues that emerge and help in development of the theory (Pidgeon & Henwood, 1996). Researchers and participants engage in conversation focused on questions related to the study (DeMarrais, 2004), which are added to an interview guide including emerging issues and categories in a GT study and are raised in the interview if they do not come up spontaneously (Pidgeon & Henwood, 1996). Intensive Interviewing allows to enter the other person's perspective (Patton, 2002), which is the key aim of a GT study (Charmaz, 2006). It allows the researchers scope to gather 'rich, in-depth' data from participants in an open, interactive manner, leading to a deeper understanding of the phenomena under study, and eventually provides a more complete picture of the perspective of the participants (Charmaz, 2006; Weiss, 1994). Hence, semi-structured interviewing as a method was selected for the study as it enabled a focused, conversational, two-way communication, while being conducted within a fairly open and flexible framework (D'Arcy, 1990), following the pace and flow of the participants to explore their subjective and social world (Charmaz, 2006). Qualitative interviewing is typified to be a great adventure, every step of an interview brings new information and opens windows into experiences of the participants (Rubin & Rubin, 1995), serving as one of the best laboratories for study of interactions (Weiss, 1994).

3.3.2.1 Interview Schedule

As Charmaz (2006) recommends, a few broad, open-ended questions (initially limited to 3-4) were framed at the beginning of the study with the aim to allow participant's experiences, case narratives and stories to emerge. Additional questions were added to the interview guide as probes and issues for further exploration when

the codes and categories began to emerge. The interview guide (Appendix 5) was reviewed by the academic supervisors prior to implementation. Pilot interviews with four respondents were conducted (two professionals each from CAMHS and voluntary sector respectively) to test the interview questions and as a practice for engaging in an open, yet focussed conversation, based on the board questions formulated. I also undertook courses on research design, conducting research interviews, and analysing qualitative data as a preparation for data collection and analysis.

The interviews began with a general question to explore the overview of the service and role of the professional in the respective agency, which was designed as an opening question for starting a conversation and establish rapport. This was followed by a broad question to understand their therapy practice with child and adolescent survivors of CSA, encouraging them to provide case narrative(s) to explain the same. The second segment was considered the core of the interview focussing on specific questions pertinent to the main research inquiry. However, by keeping the questions open-ended and broad, it was observed that usually a lot of information and case narratives were revealed by the participants in response to the first two questions. The rest of the interview primarily focussed on probing leads from information received from the participants. Initially, participants did most of the talking (Charmaz, 2006) including sharing of case narrative(s) that helped to see and understand aspects of CSA therapy as practiced by them with different cases from the inside (Charmaz, 2006). Their case narratives included details of the nature of cases they were referred and how they went about the therapeutic process from the time a child was referred to them until completion of the therapy. Detailed descriptions and case narratives helped present a picture of their therapy practice and in a way recreated the professionals' 'world' in interviews. This led to a dialogue between the participant and researcher in each interview where key issues or leads that emerged from the initial detailed sharing and case examples by the participants were probed in detail to explore emerging leads, issues and categories in-depth and breadth. Hence, it led to generation of rich and meaningful data.

Case narratives, incidents and examples were considered a significant source in interviews to draw information regarding the therapeutic practice and process followed by the professionals in different cases (Charmaz, 2006). The interviews involved talking through a case or different case examples from start to finish. This approach had several advantages. These narratives facilitated exploration of different aspects considered in therapy and factors that influence their choice of therapeutic approach or intervention practiced by them. It facilitated understanding about variation in therapeutic approaches or process followed by them in different cases and factors that inform such variations in practice. Further, case narratives and specific examples minimised the risk of receiving standardised or generalised responses (i.e. what should be done as opposed to what is done) with regards to their therapeutic practice.

Lastly, the interview closed with an open-ended and broad question, inviting the participants to share anything else they considered significant regarding their therapeutic interventions for child and adolescent survivors of CSA that was not already covered in the interview. This ensured any unaddressed perspective or experience(s) of the professionals considered pertinent by them. Even though, this was intended to be a closing question, a few times, relevant and new information and insights emerged in response to this question, which was explored if time permitted. Otherwise, it was explored further in later interviews. At the end of each interview, information about 'next steps' was provided and permission was sought for approaching them again in case need for further information arose based on emerging categories. All respondents were also requested to complete a demographic sheet at the end of the interview (Appendix 6). It was deliberately kept for the end of the interviews in order to minimise the prospects of forming any pre-conceived notions or views about the participants prior to conducting the interview.

3.3.2.2 Circumstances and Duration of the Interviews

Interviews with majority of the professionals in India and the UK were conducted within their respective agency setting, either in their therapy rooms or their

respective office, which seemed an appropriate formal setting. It provided an advantage of visiting their office, observing the therapy rooms/space, and observing the surroundings. In addition, these settings proved apt for focussed interviewing without disturbance and interruption. This venue for the interview as well as date and time was proposed by the interviewees as per their availability and convenience. Towards the later stage of theoretical sampling, five interviews were conducted by Skype (three professionals in India and two in the UK), and two interviews were conducted by phone (one each in India and the UK).

The majority of the interviews lasted an average of about one hour, with a few longer than an hour. All interviews were in the English language, both in India and the UK, hence there were no translation issues involved.

3.3.3 Data Management

Each interview, including Skype and phone interviews, was digitally recorded with the permission of the respondents. They were informed about it before commencing the interview and informed consent for the same was received. All interviews were transcribed verbatim by myself to facilitate deeper and prolonged engagement with the data (Charmaz, 2006). All participants were anonymised and any identifying information with respect to the respondents and their respective agency was removed from the transcripts. Pseudonyms were used where necessary, for example where participants introduced themselves by their names and/or referred to the names of their team members or agency affiliation.

The computer-assisted data analysis software (QSR NVivo version 9, later upgraded to version 10) was used to manage data including organising, sorting, and analysing the same.

3.3.4 Data Analysis

In grounded theory, data is collected to develop theoretical analysis from the beginning of a study (Charmaz 2006). “Grounded theory is a comparative and interactive method” (Charmaz, 2008, p. 82)”, in which researchers construct their analysis by the method of constant comparison which includes constantly comparing ideas and incidents with each other (Charmaz, 2008). Following this approach, the data analysis followed the process of comparative analysis that involved back and forth movement between data collection and analysis and comparing emerging codes and categories between and across interviews (Charmaz, 2006). This dynamic relationship between data collection and analysis is considered to be a critical characteristic of the GT approach (Pidgeon, 1996), which was thoroughly followed in this study.

Following Charmaz’s (2006) approach to coding, the data was analysed in two main steps, beginning with line by line coding followed by focussed coding. Figure 3.1 represents the steps taken for data analysis based on the CGT approach (Tweed & Charmaz, 2012, p. 132)

I started the analysis with line-by-line coding that led to descriptive codes. The codes developed through the initial data were continuously examined on an on-going basis through successive levels of analysis including focused coding, theoretical sampling, constant comparison and memo writing. This led to higher level of abstraction and interpretation to develop analytic categories until a theoretical conceptualisation in the form of a ‘core category’ developed that explained the ‘theoretical model’ of approaches to CSA therapy practiced by the professionals with children and adolescents.

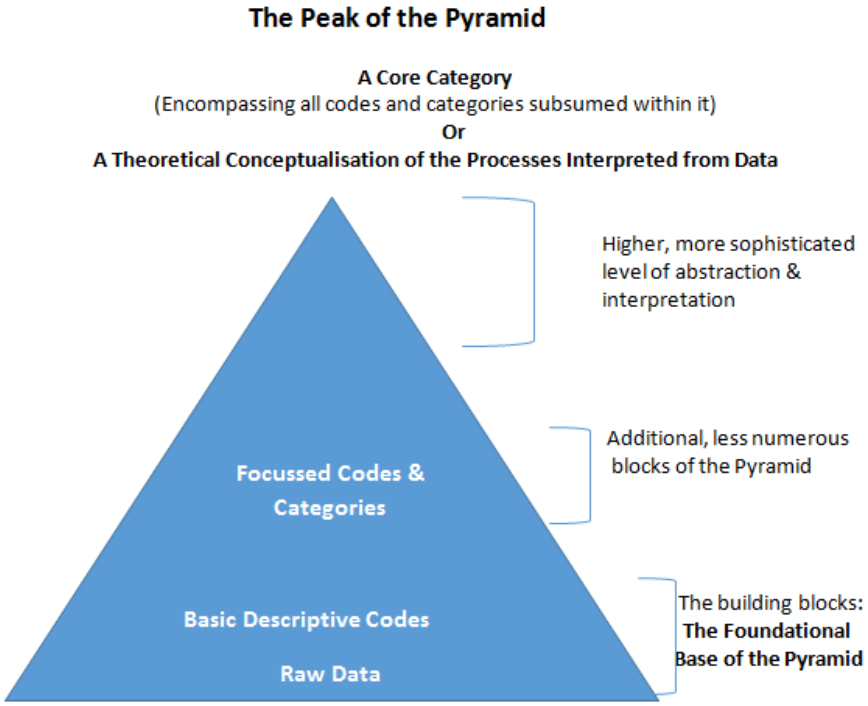

Figure 3.1: The Pyramid: Data Analysis in CGT for Constructing a Theory

3.3.4.1 Line by Line Coding

Line by line coding facilitates understanding of the data from the perspective of the respondents rather than researcher forcing his or her interpretation or preconceived ideas (Charmaz, 2006). Line-by-line coding involves naming each word, line, or segment of data (Charmaz, 2006). I started with line by line coding of interview transcripts. This helped to get grips with large amounts of data that was generated from interviews. This involved reading the transcripts thoroughly and coding each line of the interview. Although Charmaz suggests moving swiftly through the data at this stage, it took me a long time to get a grasp of data and underlying meanings in the responses of the participants. In the first attempt, I came up with a number of highly descriptive, long, and quite a few passive codes. I also had a high number of *in vivo* codes. *In vivo* codes are suggested as they help in capturing aspects that may be significant to participants (Charmaz, 2006). However, I observed that using a number of *in vivo* codes was leading to descriptive interpretations of what

participants were telling me rather than reflecting their implicit meanings and actions. 'Reflexive' discussions with the supervisors, staying close to the data, re-reading the transcripts a number of times, coding with gerunds, and writing memos helped in understanding the coding process better. I still used *in vivo* codes however tried to uncover their meanings and coded for them. For example, initially I used an *in vivo* code 'therapist's rucksack' but later changed it to 'guiding tools for practitioners'. By referring to 'therapist's rucksack', the participant was conveying how the training and discipline of professionals equips them with different tools and instruments to undertake CSA-therapy with children and adolescents. This also reflected the variations in practice of different professionals based on their discipline and training. I wrote brief informal memo to uncover and condense the meanings and actions implicit in such *in vivo* codes. As a result of these research processes and reflections, more active codes reflecting the underlying meanings, processes and actions began to emerge. Appendix 7 provides an example of line-by-line.

I paused further data collection for three-four months after conducting the initial seven interviews in order to transcribe and analyse them. I first completed line by line by line coding of the first four interviews, reflected upon them and discussed them with my supervisors before progressing to other interviews in order to become familiar with the coding process. Initially I started coding manually, however, I later proceeded to NVivo 9 (later upgraded to NVivo 10). I had over 1000 codes from these four interviews.

3.3.4.2 Focussed Coding

Focussed coding is the next level of abstraction of data that helps to "separate, sort, and synthesize large amounts of data" (Charmaz 2006, p.11) and leads to development of more analytical codes and categories compared with the first stage of line by line coding. After coding line by line, I started focussed coding of initial interviews to examine, sort and integrate large number of codes developed. I sifted through all the codes to identify the most significant and frequent codes to develop analytic categories that would explain large sections of data (Charmaz, 2006). In

doing this, comparisons were drawn between the codes developed from one interview and across different interviews that helped in identifying the emerging patterns and similarities and differences, which led to the development of analytical categories and provided ideas or areas for further exploration. Hence, similar codes were grouped together into meaningful units through constant comparison. In the process, analytical categories began to develop that were further explored through theoretical sampling to expand their properties. An example of focussed coding is provided in Appendix 8. The remaining data collection and analysis proceeded in the similar manner.

3.3.4.3 Theoretical Coding

Theoretical coding is a higher and sophisticated level of interpretation that allows the researchers to follow and further conceptualise the categories developed during focused coding by specifying their relationships (Charmaz, 2006; Tweed & Charmaz, 2012). Examining and specifying relationships between and among different codes helps in integrating them into smaller number of more analytical and robust categories, and begin to direct the path towards theory construction. At this stage, different codes and categories developed through focused coding were linked together. I undertook some of this process manually using mapping and clustering exercise (Charmaz, 2006) by grouping different codes together that were conceptually connected. Through this process, conceptual categories and their sub-categories began to emerge that reflected their links and relationships, which are explained in the ensuing finding chapters. This process of mapping and clustering followed is illustrated in Appendix 9 (picture of mapping).

An example of how coding proceeded from the stage of line by line coding and focused coding to development of conceptual categories is presented in Appendix 8. The example provided depicts how a conceptual category of ‘Stabilising Children and Adolescents’ was developed following this process of coding. ‘Assessing safety of children’ was identified as one of the significant codes during initial line by line coding of first few interviews conducted in the UK. It seemed an important step at

the beginning for taking a therapeutic decision about intake and engagement of child and adolescent survivors of CSA in therapy. I compared the interviews to look for similarities and differences in the emerging pattern. I recognised different forms of safety and stability emerging in different interviews conducted in India and the UK including physical, social and emotional safety. I explored the concept of safety further in subsequent interviews conducted (theoretical sampling) to break down its properties and understand its extent and different forms as well as interventions undertaken to address safety issues by practitioners. While the concept and forms of safety emerged as similar for all professionals in India and the UK, variations in therapeutic practice and interventions began to surface. Hence, further analysis and exploration led to refinement and development of the conceptual category of 'Stabilising Children and Adolescents', which reflected that facilitating external (physical and social safety) and internal (emotional) safety and stability was important to stabilise children and adolescents as a prerequisite to CSA therapy, however interventions differed among professionals to ensure the same.

The data analysis continued following the above process until most of the categories were saturated and conceptual categories were developed. Negative or deviant cases were also explored to test and develop the properties of emerging codes and categories. As Charmaz (2006) suggests, "codes are also provisional in the sense that you may reword them to improve the fit" (p. 48). The process of rewording some of the categories and/or sub-categories continued during writing of the drafts of the finding chapters for making them sharp and clearer. A diagrammatic representation was constructed of the interpretation of the therapeutic process from the data generated (Chapter 4), which demonstrates the relationship among different categories (Charmaz, 2006).

3.3.4.4 Theoretical or Core Category

The conceptual categories were further integrated to develop a core category that explains the theoretical model of therapeutic interventions with child and adolescent survivors of CSA (Chapter 9). This core theoretical category links all the data that

explains the social phenomenon under study and provides guidelines for action (Bluff 2005; Strauss & Corbin, 1998). The findings were also compared and contrasted with the extant literature.

3.3.4.5 Memo writing

Memo-writing is considered another integral part of the GT method and is carried out throughout the research process (Charmaz, 2006; Glaser, 1978). Memos are defined as:

> "*Write-up of ideas about codes and their relationships as they strike the analyst while coding*' (Glaser 1978, p.83).

Memos are analytic notes about the codes and categories developed (Charmaz, 2006). This is considered another way that forces the researcher to stay close to the data and acts as a self-correcting and a reflective process minimising the risk of researcher's imposition of preconceived ideas or *priori* assumptions on to the data or emerging analysis (Lazenbatt & Elliott, 2005), thereby ensuring that the constructed theory is grounded in the data generated.

Memo writing was undertaken throughout the analysis process. Different properties of the codes and categories, emerging insights ideas and reflections about the data/interviews as well as dilemmas and confusions were written on a regular basis throughout the research process. Earlier memos were more based on preliminary ideas, thoughts and confusions about emerging codes and categories including notes about ideas or emerging codes for further exploration. An example of a memo on an *in vivo* code 'therapeutic rucksack' was provided earlier. A number of diagrammatic representations of the emerging analysis were attempted in these memos to aid emerging analysis, draw comparisons between different codes and categories and/or establish relationships between and among categories. However, as the research process progressed, memos became more advanced, detailed and analytical, including defining and explicating specific properties of emerging conceptual

categories and their relationships with sub-categories. Example of an early memo, advanced memo and a diagrammatic exploration of relationships among core categories is provided in Appendix 10, 11 and 12 respectively. A number of such diagrams and early flow charts were prepared to identify and analyse the relationships between different emerging categories.

Although the steps outlined above have been explained in a linear manner, the process followed was iterative (Charmaz, 2006). It involved going back and forth in the process of data collection and analysis, which continued till the time of writing the drafts.

3.3.5 Theoretical Saturation

Theoretical saturation is described as a point in the study when new categories or insights cease to emerge and all participants are expressing the same ideas with no new properties of the core categories being revealed (Bluff, 2005; Charmaz, 2006; Glaser and Strauss, 1967).

Following the principle of theoretical saturation, the categories were considered to be saturated when new properties were not being revealed through the interviews. For example, while developing the category of 'engaging non-offending family member(s)/carers', its properties included the extent and form of engagement of families/carers including the family members involved (e.g. mother, siblings). Different sub-categories reflected the form, extent, and significance of engaging them in therapy, for example, 'enhancing support for the child', 'preparation for handling child's distress', 'handling parental/carer distress', and 'enabling therapeutic decisions about child's intake in therapy'. These sub-categories clarified that primarily it involved engaging 'non-offending parent/carer as a form of 'supportive therapy' for the child. The engagement of non-offending parent/carer was considered critical for providing appropriate support to the child survivor during difficult times in therapy. Handling parental distress associated with the child's sexual abuse was addressed by all professionals for stabilising non-offending

parent/carer and enhancing their capacity for supporting the child. Further, if they were not perceived to be stable, it impacted the professional's decision about the intake of child in therapy. Further, identification of deviant or negative cases with regards to this category enabled further exploration. These included engagement of siblings in therapy as well as providing therapy to parents for any disclosures of their CSA during child's therapy. While all professionals acknowledged the significance of therapy for non-offending parent/carer related to their histories of CSA, it was not catered for by majority of the agencies or professionals interviewed. Hence, examining different responses of the professionals during theoretical sampling including deviant cases was critical in expanding the properties and dimensions of the category, leading to a fuller and in-depth understanding of the phenomenon. Hence, the category of 'engagement of non-offending parents/carers' was saturated when no new accounts reflecting the form and extent of their engagement emerged from the responses of the professionals.

Similarly, another example is regarding the category of 'facilitating ensuring safety of the child' where its different properties related to 'internal' and 'external' safety were revealed in different interviews and different ways in which professionals in India and the UK addressed these aspects therapeutically. The same process was followed for almost all the categories, where they were considered to be saturated when no new insights or properties were being revealed.

Although saturation helps in deciding when to stop data collection, it is considered difficult to categorically state if saturation has been achieved (Bluff, 2005). In this study, although saturation was considered to be achieved with regards to majority of the theoretical categories developed, challenges with the same were noted as well. It cannot be stated with certainty if all the categories were completely saturated, due to the research and sampling limitations. For example, the categories of 'barriers to disclosure' or 'Social Action' within the UK cultural context including the ethnic minority communities are not considered to be saturated completely. Most of the CSA-Specialist agencies and voluntary organisations in the UK included in the study only took referrals for therapy if CSA was disclosed and investigated. However, they

were primarily focussed upon in the study as the key questions pertained to the therapeutic approaches practiced for CSA-therapy and they were considered as 'significant individuals' or 'experts' to address the research questions. Further, not many organisations were found in the UK that worked with ethnic minorities and the ones who were identified did not have a clear therapeutic focus with lack of therapists or counsellors in their organisation including those that were included in the study. People from ethnic minorities were not found to be accessing CSA-Specialist services. In India, no new professionals working on CSA issues or providing CSA-specific therapy could be found to recruit for the study. Three to four other MH professionals were identified for their work on CSA-therapy, however they did not respond to emails or phone calls made by the researcher. Hence, the focus on primary research questions as well as limitations of access and time in some cases was also considered when deciding to stop data collection. Dey (1999) suggests the concept of "theoretical sufficiency" (p. 257) rather than saturation (Charmaz, 2006). The theoretical model that has been constructed is grounded in large and varied dataset from two different countries and 'sufficiently' accounts for the data collected, with most of the categories that were considered to be completely saturated. Any further data collection would not have significantly added to the developed theory.

3.4 Reflexivity

Reflexivity is defined as recognising and acknowledging the "role played by personal, ideological and cultural assumptions in Knowledge" (Pidgeon & Henwood, 1996, p. 101) as well as the relationship of the researcher with the participants (King, 1996). The researcher's stance in qualitative research including GT is considered to be that of an 'insider' (Warwick-Booth et al., 2012). Reflexivity is considered critical in CGT due to the acknowledgment of the collaborative role of the researchers in the research process and construction of the theory. Grounded theorists often begin their studies with certain research interests referred to as sensitising concepts or points of departure (Charmaz, 2006). These are considered as interests, concepts or disciplinary perspectives that guide the researchers at different times in the research from data collection to analysis including forming interview questions and listening

to participants. Hence, perspective of the researcher is considered significant so that it guides them to build the analysis. At the same time, it requires the researchers to be mindful of their own preconceived notions and assumptions so that it does not influence the data generated and analysed (Charmaz, 1990, 2006; Pidgeon, 1996). A need to maintain a fine balance between researcher's own subjective understanding or perspective and data collected and analysed from the participants is emphasised in order to construct a theory that is grounded in the data (Glaser and Strauss, 1967; Pidgeon & Henwood, 1996). The process of reflexivity enables the researchers to maintain this balance.

The process of reflexivity began early and continued throughout the research process. A reflexive diary was maintained at every stage of research including the initial planning of research methodology and design, formulating interview questions, conducting interviews and analysis. Further, reflexive discussions with the supervisors throughout the research process helped in keeping a check on personal ideas and notions. Although it was considered significant throughout the research process, it was most meaningful at the initial stages.

The interest for this research emerged from my professional association in the area of gender and sexuality including gender-based violence, CSA and trafficking in women and children in South Asia. My work with an NGO on CSA-issues in India sensitised me to the gaps in policies, services and therapeutic interventions for survivors of CSA and formed the core motivation for this study. Hence, I started with a subjective stance and interest in the topic, having been a practitioner for a number of years in this field. Hence, learning to be reflexive was an essential part of my journey and new role as a researcher. The discussion around reflexivity took place with my supervisor early on in the research process, where I was advised to maintain a reflexive diary. It helped me to stay mindful of the knowledge gained previously through my past involvement and how my notions and assumptions might influence my role in the study and research process. Further, as already discussed, a number of processes built into the CGT methodology proved to be self-corrective (Charmaz, 2006), which reduced the likelihood of any subjective experiences seeping in. For

example, when thinking of the research questions, my first list consisted of more than twenty questions informed by past knowledge. Reflexive discussions with my supervisor about the need to ask these questions, writing down my thoughts about it while revising the questions, and following the CGT approach to semi-structured interviews i.e. keeping the initial questions limited to a few broad open-ended questions initiated process of reflexivity. Having three broad interview questions ensured that I did not raise the topics or issues that I was interested in exploring but followed leads from the responses received from the participants. I practiced this in the pilot interviews conducted to ensure that I stuck to the broad questions formulated and further followed leads from the participants rather than raising issues that they did not bring up.

Further, the relationship and interaction between the participants and researcher is considered important as it impacts the data collection (Mills et al., 2006b). Hence, how the researchers conduct and present themselves and how they are perceived by the participants would influence the data generated. This was observed in my interaction with the participants. I made notes after interviews to reflect upon these interactions and any possible impact on their responses and/or nature of involvement. Being aware of my position in the research interviews was considered important. As mentioned earlier, I knew some participants in India due to my past involvement with CSA-work. I myself felt, and was perceived as, an 'insider' by the participants in India, and I observed their expectation of a shared understanding of CSA between us. In some occasions during the interview, a common phrase that I heard from a number of participants was, "you know how it is in this field in India", assuming a level of awareness and familiarity with the topic and its subtleties and complexities in India. On the other hand, when I started data collection in the UK, initially I felt some discomfort and felt like an 'outsider' being from a different country and first time engaging in such an intimate conversation on a sensitive topic with completely unknown people from a different cultural context. Reflexive accounts of my feelings, difficulties, and experiences and any possible impact of these different positions and perceptions were recorded after interviews. These accounts as well as discussions

with academic supervisors helped increase awareness and ensured a more open and balanced interaction with the participants.

Similarly, reflexivity was ensured during analysing the data as the interaction between the researcher and the data is also considered significant (Cutcliffe, 2000). I followed the ideas and codes emerging from the data throughout. In the process, my assumptions and hunches were challenged a number of times. For example, I explored the theme of social action that I did not expect or anticipate as an intervention that could have therapeutic advantages for child and adolescent survivors of CSA. Hence, by immersing myself completely in data and an attempt to keep my preconceived assumptions and ideas at bay helped me gain new insights and learnings and ensured that the theoretical model developed is grounded in the data generated.

3.5 Ethical Considerations

Ethical approval was ensured from the Research Ethics Committee of the School of Health in Social Science at the University of Edinburgh by completing and logging the Level 1 self-audit (Appendix 13) prior to starting the data collection. Since the study involved interviews with CAMHS/NHS professionals, an email was sent to an NHS official to clarify the procedure of ethical approval for the same (Appendix 14). It was clarified that in a study involving interviews with NHS professionals, full NHS ethical obligation (Integrated Research Approval System**)** was not required (DH, 2011b).

Verbal and written informed consent of the professionals was also ensured. In addition, complete information about the study with contact details of the researcher and primary supervisor was provided to all the participants. Further, the information about the study and voluntary participation was reiterated in the brief presentations made to the teams or managers/directors of agencies prior to recruiting the participants. All participants, both in India and the UK, agreed to participate in the

study voluntarily and provided appointments and chose venue for interviews themselves as per their availability and convenience.

Issues of anonymity and confidentiality were also discussed with participants and ensured at every stage. All the interviews were transcribed by myself, which ensured complete confidentiality of the data collected. In written transcripts, names of the respondents and any identifying information such as the name of the agencies were removed or replaced with pseudonyms as required. In the analysis and main findings, participants are recognised with their occupational affiliations (for example, psychiatrist, clinical psychologists, art therapist, or counsellor) and setting (such as CSA-specialist service, voluntary organisation) rather than the names of individuals and agencies to ensure the anonymity and confidentiality. The geographic site of the study was extended to Scotland and England in the UK so that the scope of identification of any agency/service could be minimised to the maximum possible extent. While some agencies in India and the UK were happy for their name to be revealed in the study, others were quite uncomfortable. Hence, to ensure consistency, names of all participants and their agencies have been anonymised in the study.

The hard-copies of the data were stored securely in an office locker (at the University) and all soft copies/electronic files were saved in a password-protected laptop belonging to the researcher. Only the researcher and academic supervisors had access to the data generated during the study.

Due to my past work with child, adolescent and adult survivors of gender-based violence and CSA, I felt that I had the required sensitivity, integrity and professionalism to engage with the professionals on this sensitive subject of CSA. At the same time, I was mindful about the cultural and contextual variations between India and the UK while interviewing the participants. The adoption of the GT approach, reflexivity throughout the research process and numerous interactions with my supervisors at different stages of research process ensured that I was guided by my past knowledge, understanding and sensitivity to the topic, while not being

influenced or biased by it. This ensured that the research was conducted in an ethical manner.

3.6 Quality of the Study

Different criteria have been recommended to assess the quality of a qualitative research study, including various terms used such as reliability, validity, trustworthiness and authenticity, credibility, and relevance (Holloway, 2005). For example, Yardley (2000) proposed the criteria of sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance to assess the quality of qualitative research. Specifically in a GT study, criteria of fit, relevance, workability and modifiability have been proposed (Glaser and Strauss, 1967). In this study, the criteria proposed by Charmaz (2006) for assessing the quality of a CGT study have been adopted, which includes credibility, originality, resonance and usefulness. However, there are considerable overlaps in the above criteria proposed by different researchers.

3.6.1 Credibility

Credibility is evaluated by the extent to which the findings represent or explain the phenomenon under study from the perspective of the participants as well as appropriate adherence to the research method (Charmaz, 2006; Lazenbatt & Elliott, 2005). Ensuring methodological rigour is considered to increase credibility of the findings and overall quality of the study (Cooney, 2011; Cutcliffe, 2000), and it includes providing a clear description of how the methodology was applied (Cooney, 2011).

The CGT research methods and processes followed in the study have been described in detail throughout this chapter. The inherent processes of CGT methodology including line by line coding, focussed coding, theoretical sampling and constant comparison were considered significant for assisting me in staying close to the data. These proved to be self-correcting processes (Charmaz, 2006) to ensure that the

theoretical model or core category and sub-categories developed are grounded in the responses of the participants. Prolonged engagement with data by transcribing the interviews myself and reading these a number of times during line-by-line coding was the first step in immersing completely in the data. Taking a break from collecting further interviews till first seven interviews were coded and engaging in reflexivity by writing down my hunches as well as reflexive discussions with supervisors at this stage helped in stepping back from preconceived ideas and notions. The tendency to draw themes based on my *priori assumptions* (Murphy, Dingwall, Greatbatch, Parker & Watson, 1998) was extensively questioned and corrected at this step. Each step in the research process, like an adventure (Rubin & Rubin, 1995) or a journey, took me closer to the participants' world, which included checking and exploring emerging themes in each subsequent interview through theoretical sampling and constant comparison between and across different interviews including data collected from India and the UK, and writing analytical memos and reflective notes/diary. These steps ensured that the emerging theory is a reflection of the 'world' of the participants as understood by the researcher by following the route shown by CGT methodology. Cooney (2011) suggests using excerpts from the data to support the findings as another credibility criterion for a GT study, which has been followed in the ensuing chapters.

In a GT study, an extensive literature review is recommended only after the analysis, as it ensures that the emergent theory will be inducted from the data generated and not influenced by existing theory or theoretical underpinnings (Cutcliffe, 2000). A preliminary literature review was done at the beginning of the study to identify gaps and for conceptual clarity (Cutcliffe, 2000). However, a more extensive literature review was done after the analysis and is weaved into the findings and overall discussion of the theoretical model constructed. This ensured that the findings represent the participant's perspectives, experiences and actions completely.

Suitability and sufficiency of the data collected are considered other indicators of credibility of the study (Charmaz, 2006). Data for the study was collected from professionals engaged in CSA-specific interventions in two different countries and

socio-cultural contexts, which enhances the cultural relevance of the theoretical model constructed. Further, participants were drawn from different settings that engage in CSA-therapy with children and adolescents. Most professionals had a number of years of experience in this field and were considered to be experts or significant individuals who could provide information relevant to the research questions. Further, as discussed earlier, theoretical sufficiency was deemed to be achieved in categories developed that led to construction of the theoretical model.

Respondent validation or expert-opinion or feedback (Cooney, 2011) is another way of increasing the credibility and relevance of the findings. While some researchers do not accept respondent validation as an accurate means of testing accuracy of the findings (Murphy et al., 1998), others posit that this process is already built in the GT methodology (Lazenbatt & Elliott, 2005). Cross-checking and examining emerging codes and categories with different participants in subsequent interviews was done throughout the data analysis stage, which is considered a way of member validation (Charmaz, 2006; Lazenbatt & Elliott, 2005). Hence, it is suggested that in a GT study it is not required to go back to the original participants to check their agreement about the researcher's interpretation of data, and researchers may opt not to use member validation (Cooney, 2011; Lazenbatt & Elliott, 2005). It is considered more important to connect with other people or groups and experts to check if the findings and the model or theory constructed from data fits their experience, context or situation (Cutcliffe, 2000; Cooney, 2011; Lazenbatt & Elliott, 2005). If the findings are grounded in data from the participants and represents their social reality, it is believed that the outcome should fit and thus be recognisable to other people who may be familiar with the social setting or phenomenon under study (Bluff, 2005; Glaser and Strauss 1967; Strauss and Corbin, 1998). I did return the interview transcripts initially to some participants for clarification and ensuring accuracy. However, I shared the findings, emerging categories and the theoretical model with different experts from the field, which included researchers and practitioners from India, UK and other South Asian countries (Sri Lanka). These included a researcher on community mental health issues from India, a psychiatrist and an academic on CSA-issues from India, a researcher and a psychotherapist on CSA-trauma issues

practicing in Scotland, and a researcher and practitioner on trauma issues from Sri Lanka. In addition, the emerging analysis and drafts of the findings were discussed with the academic supervisors throughout the research process. Such reviews are also considered to enhance the analytic process (Bluff, 2005). The discussions with supervisors and other experts were found extremely helpful for developing the analysis at different stages and offered valuable insights to the development of the theoretical categories and model.

3.6.2 Originality

Originality in research is assessed if a novel or original contribution is made through the study by offering insights or analytical framework in a new area or new learnings in an established field and/or adding value by expanding current ideas and theoretical frameworks cutting across disciplines or fields (Charmaz, 2006, p. 153). Various factors reflect the originality of the study and research findings. First, there are a number of gaps in extant literature in the field of therapeutic interventions for child and adolescent survivors of CSA (Chapter 2). Not much is known about the actual therapeutic practice in different settings in both India and the UK and what is the practice informed by. Hence, the findings of this study would expand learning in an area that is considered to be in its infancy. Further, initial as well as a more extensive review of literature after the analysis indicated that there were no culturally-specific theoretical or therapeutic guidelines that could guide the sampling or emerging analysis as well as development of the theoretical model. This also indicates that the conceptual categories and framework/model developed is an original contribution to the field of CSA therapy, grounded in the participants' experience, perspectives, actions and cultural context (Cutcliffe, 2000). These aspects are discussed later where the findings and theoretical model of practice are presented.

3.6.3 Resonance

Sharing the findings with experts and other people or groups in the field helps to assess the usefulness and resonance of the findings, and check if the conceptual

framework developed fits their experiences or 'social reality' and offers them deeper insights about their lives and social worlds (Charmaz, 2006; Cooney, 2011; Lazenbatt & Elliott, 2005). In addition to the review by expert researchers and practitioners, I presented the emerging analysis and theoretical model at different seminars and conferences. This included a presentation and discussion on the findings at an annual staff meeting of Rape Crisis Scotland, where field staff including therapists from their thirteen centres from across Scotland were present (written permission taken to include their name and feedback in the thesis). Feedback received from different experts including practitioners and researchers from the field suggested the theoretical model constructed is transferable as it resonated with them and they found it useful for their practice. They confirmed that the theory/theoretical model reflected their experience and resonated with them.

3.6.4 Usefulness

Checking the usefulness of the findings with people who will use the theory is considered important (Cutcliffe, 2000). The independent practitioners from Scotland, India and Sri Lanka as well as the staff from the Rape Crisis Scotland expressed that the model would be useful in their practice. The coordinator of the Rape Crisis team shared that their network resonates with the findings and the theoretical model developed and found it helpful for their work.

Charmaz (2006) suggests that, "a strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of the contribution" (p. 183). Further, strengths of the study and its significance and usefulness with recommendations emerging for future research are discussed in chapter 10.

3.7 Limitations of the Study

Sufficient consideration to uphold the quality of the study was ensured through meticulous and systematic application of the CGT method and ongoing consultations

with the supervisors. However, certain limitations of the study were noted due to the time and resource constraints in a doctoral project.

There are inherent limitations of a qualitative study including grounded theory method, such as subjectivity including researcher and informant bias, reactivity, generalisations and reliability (Creswell, 2007; Seale et al., 2004). Since there was only one researcher involved in conducting the research and the only method of data collection was individual interviews with the professionals, subjectivity and bias, both the researchers' and participants, could be considered as possible limitations. However, self-corrective processes built in within CGT (Charmaz, 2006) and its careful application helped in minimising subjectivity. Further, consultations with academic supervisors and other practitioners and experts in the field ensured open discussions and reflections throughout the research process.

Further, in a CGT study, there are concerns regarding saturation where the researchers may assume that all categories have been saturated when they may not have (Charmaz, 2006). The legitimacy of saturated categories can be questioned in a GT study. Considering this limitation, Dey (1999) proposed the concept of "theoretical sufficiency" (p. 257) to 'saturation' and claimed that the categories are suggested (not saturated) by data. Although care was taken in applying CGT method to ensure that most of the categories were saturated, I contended with theoretical sufficiency in some instances. To a large extent, it was linked to the other perceived limitation of the study regarding sampling. The sample in the UK consisted of professionals associated with the CSA-Specialist statuary services and voluntary organisations. Their primary remit was to provide therapy services and they received referrals only after CSA was disclosed and investigated. This aspect was discussed earlier in chapter two. As a result, not much information was received about identifying and accessing children who have yet not disclosed CSA in the UK whereas the large part of the data generated in India focussed on this aspect. Further therapeutic services were found to be limited in India. A few other professionals (four) in India who were found to engage in CSA-therapy could not be accessed for the study. Thus, the data on actual CSA-therapy is based on a small sample in India.

Similarly, only two ethnic minority organisations could be accessed in the UK, who were not found to be providing therapy services for CSA, especially to children and adolescents. Gaps in these areas in the study remain, however based on the data generated, theoretical sufficiency in the associated categories was deemed to be achieved. Considering that there were two diverse data sets included, it minimises the impact of these limitations on the study.

Lastly, due to the small scale and sociocultural specificity, extending and applying the findings to varied populations is considered to be a limitation of qualitative research (Edmeades et al., 2010). This limitation may be relevant in this study. However, varied data set from two different countries representing multiple settings or agencies that provide CSA-therapy services to children and adolescents increase the scope of extending the findings to broader populations. Feedback received at the presentations made so far at different seminars and conferences including the presentation of the theoretical model at the annual meeting of the Rape Crisis, Scotland as well as comments received from other experts and practitioners from UK, India and other countries of South Asia (Sri Lanka) indicate that they found the findings useful and applicable.

3.8 Conclusions

The significance, rationale and application of CGT as the research methodology for this study have been presented in this chapter. All the steps followed leading up to the core conceptual category or theoretical model have been outlined. The chapter included the ethical considerations as well as deliberation on the limitations and quality of study establishing its credibility and rigour.

The findings are discussed in chapters 5-9, beginning with an introduction to the findings and establishing context (chapter 4) followed by discussion on four principal categories (chapter 5-8) that build up to the theoretical model developed (chapter 9).

Chapter Four

The Findings: Introduction and Establishing the Context

"We are a therapeutic service so we will see children and adolescents up to the age of 18 who have been sexually abused."

(Clinical Psychologist 1, CSA-Specialist Service 1, UK)

4.1 Introduction

The findings are presented in five chapters: chapters 4-8, followed by overall discussion, recommendations and conclusions in Chapter 9. Chapter 4 provides the context and an introduction to the phase-based process model of interventions and therapeutic pathways practiced with child and adolescent survivors of CSA, developed based on the interviews with the practitioners in India and the UK. This process model consists of four phases, which are described in chapter 5 to 8 respectively. Each chapter is divided in three key parts. Part one explains the frame of reference of the professionals interviewed for the study in India and the UK, which highlights their understanding that govern the therapeutic interventions practiced by them in the respective phase. Part two presents the interventions and approaches practiced by them, and the third part presents the conclusions, discussion and summary. These findings have been integrated to discuss the implications for a culturally-relevant theoretical model of approaches to CSA therapy for children and adolescents, presented in Chapter 9.

4.2 The Phase-based Process Model: Interventions and Therapeutic Pathways with Child and Adolescent Survivors of CSA in India and the UK

Therapeutic processes and interventions for sexually abused children and adolescents progress through four phases, based on goals of the interventions identified by professionals. These goals are influenced by the socio-cultural context, structural factors, needs of child and adolescent survivors and/or trauma conceptualisation by

the practitioners in different settings (CSA-Specialist services of CAMHS, voluntary Sector, and private practice). Further, the findings indicated that the socio-cultural context governs how CSA is understood and conceptualised within a particular culture. This has a huge impact on the expression, manifestation and articulation of CSA experienced by children and adolescents as well as on the service provision in the area of CSA. Trauma conceptualisation, on the other hand, seemed to be informed by the orientation and training of the therapists and/or the agency/setting they were associated with. While interface of socio-cultural factors with trauma conceptualisation may be possible, the latter was seen to be positioned largely within a more universal, wider trauma therapy perspective and therapeutic schools. Different phases that the interventions and therapeutic practice on CSA were found to progress through include: **1. Social Action Framework**, with the goal to identify silenced and invisible children, particularly in a culture of silence and suppression in India; 2. **Stabilisation and Resilience Building Framework**, with the aim to ensure safety and build a foundation for the ensuing CSA-trauma specific therapy, practiced both in India and the UK; 3. **CSA-Trauma Resolution Framework**, where the goal is to address the CSA trauma to help restore the traumatised child, more visible in therapeutic practice in the UK; and 4. **Maintenance and Relapse Prevention Framework**, which aims to prevent relapse and protect from further harm and revictimisation by signposting possible future developmental difficulties associated with CSA. These phases may be mutually exclusive, follow a linear trajectory, or there may be a back and forth movement from one phase to the other. Professionals face a number of challenges and stresses in working on CSA due to the associated complexities, commonly referred to as vicarious traumatisation, which has also been discussed.

Figure 4.1 depicts step-by-step outline and a summary of the ‘Phase-based Process Model’ of interventions and therapeutic pathways with child and adolescent survivors of CSA in India and the UK.

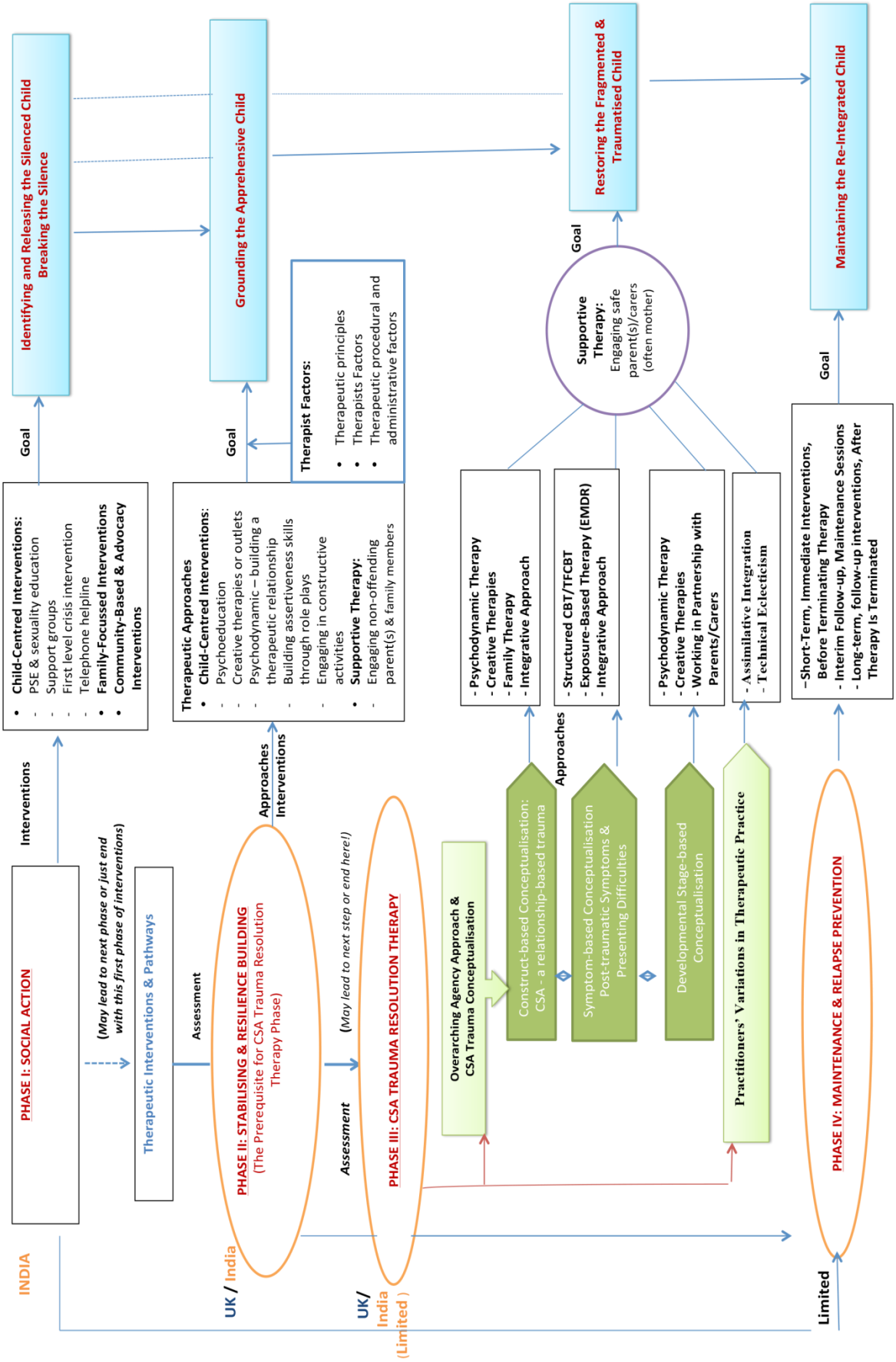

Figure 4.1: Phase-based Process Model of Therapeutic Interventions with Child and Adolescent Survivors of CSA in India and the UK

4.3 The Context: Interventions and Therapeutic Pathways with Child and Adolescent Survivors of CSA in India and the UK

The context within which the therapeutic interventions take place in India and the UK is discussed in this section. Three key aspects that describe the context of interventions on CSA with child and adolescent survivors have been identified based on the responses of professionals interviewed in India and the UK. These findings have been substantiated by the review of literature, policy documents and relevant government and other websites. These include: i. The child context; ii. The CSA context; and iii. The service context.

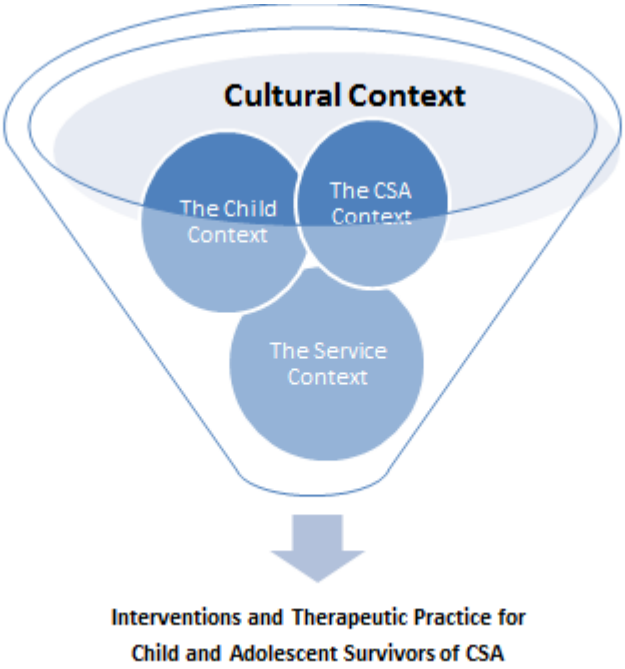

Figure 4.2: The Context of Interventions with Child and Adolescent Survivors of CSA in India and the UK

Different interventions and therapeutic practices seem to operate within the context of 'the child' or children who are sexually abused; the context within which CSA takes place, and the structural factors and mechanisms in each country within which the CSA-specific services are set up. These, further, seem to be deeply entrenched

with the cultural context, which has an influence on the therapeutic provision and access for sexually abused children and adolescents and their families.

4.3.1 The Child Context

The findings revealed that interventions and therapeutic pathways relate to two extremes of sexually abused children and adolescents. On one end of the spectrum, there are 'invisible or hidden children' who have not made their way to the therapeutic service provision due to silence and suppression that shrouds CSA. On the other end, a large majority of children who are referred for therapy are reported to be severely traumatised with most of them experiencing complex trauma.

Invisible or Silenced Children **Severely Traumatised Children**

The group of 'invisible or silenced' children was primarily reported by the professionals in India, with a few indications of the same received from the therapists in the UK, particularly those from the voluntary organisations working with ethnic minorities. In these cases, interventions seemed to be primarily geared towards breaking the silence and identifying these hidden and silenced children, particularly in India. A large part of the interventions undertaken in India fall under the first phase identified in the process model i.e. the 'Social Action Framework' that focusses on addressing the cultural barriers that prevent disclosure and action on CSA (including seeking therapeutic help). These interventions are largely family and community-based, and are considered to be therapeutic by some professionals in India as these facilitate disclosure, and release children and adolescents from the suppression of keeping their sexual abuse a secret. Furthermore, through these interventions, professionals attempt to enhance support for children from the families/safe parent, usually the mother, after the disclosure of CSA is made. The understanding of the professionals of the cultural context, including social and structural factors that push children into silence and invisibility, as well as the interventions practiced to address these barriers are discussed in the next chapter.

On the other end, the CSA-Specialist agencies primarily in the UK were found to be particularly catering to the severely traumatised and symptomatic child and adolescent survivors after disclosures were ensured.

> "*We probably get sent the more severe children who are more severely affected. We get some straightforward ones as well, but I think if you're severely affected and you're presenting either a lot of complexity or a lot of risk, even voluntary agencies are likely to send them to us because of the multi-disciplinary team."* (Psychiatrist, CSA Specialist Service 3, UK)

Some professionals in the UK acknowledged the pressure of having to focus more on complex and severely affected children due to the remit of their agencies of being a multi-tier and multi-disciplinary CSA-Specialist service. Resource constraints and funding pressures compelled them to be selective in their service provision, which was found to be consistent with the review of service provision for sexually abused children and young people in the UK (Allnock et al., 2009).

> "*Because of the financial pressures, I think we are getting more pushed to work more with the extreme end em and trying to encourage other services that they can manage the less extreme end.*" (Play Therapists, CSA Specialist Service 1, UK)

It cannot be inferred that the 'silenced or invisible children' referred to by the professionals in India as well as those who have possibly not disclosed CSA in the UK are not severely traumatised or other asymptomatic children do not require therapeutic support. However, due to cultural factors primarily in India, and the ways in which CSA-specialist services and agencies seemed to be set up in the UK, the therapeutic needs of these children apparently are being ignored. The findings revealed a gap in the therapeutic services in this regard. Recent studies in the UK confirm that a high number of sexually abused children in the UK are not detected, reported and treated (Allnock et al., 2009; NSPCC, 2015a). Asymptomatic children have also been ignored in most of the empirical studies with sexually abused children, which has been criticised in the review of literature.

At the same time, the majority of professionals interviewed in India and the UK confirmed that girls are mostly referred for therapy. While some professionals

attributed this to a higher numbers of girls being sexually abused, a few recognised the barriers for boys to disclose CSA. Social and cultural norms related to masculinity were reported to be the barriers for boys to disclose CSA. Hence, these boys presumably may be part of the 'invisible or hidden children' group both in India and the UK.

> *"So they've* (referring to boys) *often been more abused, you know, abused for longer than girls, so that's an issue for them.. I'm not sure I've got to defend it very strongly, but I think it's true to say that for boys, to have been sexually abused, usually by men…, then they think, the boys, the victims think that they should be, there must be something very, very wrong with them to have been selected. And that if they were* ***tough*** *enough and man enough, they would have been able to fight off the abuser and protect themselves."* (Psychiatrist, CSA Specialist Service 4, UK)

However, gender of survivors did not appear to have an impact on the therapeutic process or approaches practiced by professionals. The impact of the CSA trauma experienced was considered to be similar on boys and girls, even though its expression or manifestation may be different.

> "*I mean there are stats. on how boys deal with trauma and how girls deal with trauma. But my experience in the therapeutic space is sometimes in more, in the play that will have to be more the fight or more the challenge of defeat but that's a symbol, whereas the symbol will manifest in a different way in the way you know some female clients will work… It's just a different image, the language is the same*." (Play Therapist, CSA Specialist Service 1, UK)

Another relevant aspect identified in regards to the 'child context' is the age of the children referred for therapy. Most professionals in the UK, and a few in India who provide therapeutic services, reported that they work with children up to the age of 18. Though there was no lower age limit reported, the youngest child seen by all practitioners in India and the UK was about 3-4 years old. The age of the child had implications for the choice of therapeutic modality and approaches practiced.

> "*So we are nothing to 18, all the way kind of through em but typically wee bit younger ones."* (Clinical Psychologist, CSA Specialist Service 2, UK)

"*Well, the youngest child that I can remember doing this kind of work with was 3*." (Clinical Psychologist 2, CSA Specialist Service 1, UK)

4.3.2 The CSA Context

Professionals in India and the UK reiterated that CSA is a complex issue to work with due to multiple vulnerabilities and complexities that children present. These factors account for the diagnosis of 'complex trauma' in most of the children referred for therapy.

"*Em I think the reality is that the majority of the cases we have are very complex*." (Clinical Psychologist, CSA Specialist Service 1, UK)

Complex trauma is related to multiple traumatic experiences or stressors, including repeated episodes of CSA or other forms of prolonged social and interpersonal traumatic events experienced during developmentally vulnerable times such as childhood and adolescence (Ford & Courtois, 2009; Herman, 1992). The experiences of most children as shared by the professionals interviewed in India and the UK correspond with this definition of 'complex trauma'. Intrafamilial CSA was confirmed in most of the cases. Most children referred for therapy were reported to be sexually abused by someone from within the family or someone who was in a position of a care giver, trust and/or authority with the child.

"And most often, the people (referring to the abuser)*, like, in most cases, they're even known to the family very well and they're trusted by the family very well*." (Founder & Counsellor, Voluntary Organisation 6, India)

Consistent with the literature review, professionals reiterated that the impact of CSA was severe when the perpetrator was from within the family as it involved greater issues of trust, betrayal and impact on relationships. Further, intrafamilial abuse was repetitive and prolonged (usually ongoing for a number of years) before it stopped and/or was disclosed, leaving a deeper and a more severe impact on the survivors.
Another reason for complex trauma in children and adolescents was linked by the professionals to polyvictimisation or multiple traumatic experiences suffered prior to

or alongside CSA. Most of the professionals in the UK and few in India reported receiving only a few cases where sexual abuse was found to be the only traumatic experience.

> *"Breakdown in the maternal relationship; domestic violence; poor housing; being bullied; umm absent fathers; inconsistent fathers coming in and out of their lives - sometimes kind of more present, more of an issue than actually the sexual abuse, which was interesting to me because I guess you think the nature of the sexual abuse is so awful and traumatic that that would be the one thing that you wanted to kind of treat."* (Social Worker, CSA Specialist Service 3, UK)

> *"I realised that whatever happened to them, on surface, the abuse for what they were here, the sexual abuse, it was just the tip of iceberg. You know the kind of background, the attachment uhh damage…, neglect and the amount of emm abuse emotional abuse, physical abuse which was present in their life from the beginning. I think that was too big."* (Independent trauma therapist, India)

Issues of multiple abuse, neglect and/or dysfunctional families were felt to make children vulnerable to CSA in the first place, and lead to complex trauma. Within this context, a few practitioners in both countries discussed parental history of CSA as a risk-causing factor for the child. This also raised concerns and challenges regarding trauma-therapy for parent(s) with history of CSA.

> *"Emm also, the idea that if you've got a parent who's been sexually abused themselves, maybe they have got issues with their own sense of boundaries and privacy and self-respect. Again, it makes them easier targets to be exploited*." (Social Worker, CSA Specialist Service 3, UK)

Most of the professionals, especially in the UK, confirmed receiving cases of children with such complex and severe traumatic experiences, and its influence was observed on the therapeutic interventions practiced by them.

4.3.3. The Service Context

As discussed earlier, therapeutic service provision for child and adolescent survivors of CSA is quite different in India and the UK. This also to some extent had an influence on the nature of interventions practiced by the professionals. The statuary CSA-Specialist services and voluntary organisations included in this study from the

UK had a clear remit of providing therapy to child and adolescent survivors of CSA. As part of the statuary Tier 3 services of CAMHS, the CSA-Specialist services accepted referrals only of those children where CSA was disclosed and investigated. Most of them did not accept self-referrals.

> *"That's the main set of criteria, that they've been sexually abused but it's been reported and investigated. We won't take kids' words if there hasn't been an investigation yet."* (Clinical Psychologist, CSA Specialist Service 1, UK)

Further, being specialist Tier 3 services, most of them acknowledged their remit of catering to children with severe symptoms or disorders caused due to CSA. This explains their emphasis and focus of therapeutic interventions for severely traumatised or symptomatic children.

> *"Well, I suppose, bearing in mind that we're kind of a mental health service, a Tier 3 mental health service, our remit is really about Axis I diagnoses primarily, that's our main kind of service. Umm it's much more common to see those children being referred, like I said, for post-traumatic stress disorders – anxiety, eating disorders, depression, self-harming – as the result of being victimised and being sexually abused."* (Social Worker, CSA Specialist Service 3, UK)

Most of the agencies in the UK, both statuary and voluntary sector, had trained, multidisciplinary mental health practitioners. These included clinical psychologists, community psychiatric nurses, child psychotherapists, social workers, play and art therapists. Few CSA-Specialist agencies also had child and adolescent psychiatrists, usually heading the teams. However, most teams seemed to be diminishing and had part-time staff due to funding constraints.

> *"It's a small team at the moment, it's been bigger in the past. It consists of... play therapist…, an art therapist, and doctors in training, psychiatrist and child psychiatrist in training and myself. And in the past, we've had family therapists, psychotherapists, child psychotherapists, and social workers, psychologists – we've had a range. At the moment, just quite a small team."* (Psychiatrist, CSA specialist Service 3, UK)

Consistent with the review of service provision (in Chapter 2), it was found that facilitating disclosures and ensuring interventions for overall child protection and safety was considered to be the responsibility of the Universal services and teams

(Tier 1). This implied that investigation of CSA, ensuring a safe and stable environment around the child, as well as referrals to these CSA-Specialist services (Tier 3) and follow up on the ground (outside the therapeutic set up) with children and adolescents was undertaken by the Universal services. This ensured that the CSA-Specialist teams could focus solely on providing therapy to children and their families.

> "*So you're providing a particular kind of help that, but you know, you may often need people, like social workers, to help insure the child's overall safety. So you're providing one component of the overall plan to help."* (Psychiatrist, CSA Specialist Service 3, UK)

Even the voluntary organisations providing CSA therapeutic support to children and their families in the UK had trained, multi-disciplinary teams although not as wide as the CSA Specialist services.

None of the above service context existed in India. In contrast to the service provision in the UK, the findings confirmed that most of the work on CSA began and continues with the efforts of NGOs in India. This included work related to prevention of CSA as well as therapeutic support. Even though, majority of the trained mental health professionals, primarily clinical psychologists and psychiatrists, were found to be based in hospitals (largely private hospitals) or in independent private practice, very few cases of CSA, both adult and children, were received by them.

> "*See in India in a hospital setting specially in a private hospital setting aa. we get very rare cases which is direct referrals for….CSA. So far in my personal experience, I am working here for the past seven years. I have seen direct two cases where direct referral had come for… CSA. The cases where it gets referred or picked up by like, you know police and all that, they are referred to the NGOs for basically first level crisis counselling*." (Clinical Psychologist 1, Private Hospital, India)

> *"It's actually NGOs who started the trend (*referring to the work on CSA), *to be very honest, because they, in any case, violence work and CSA work has come because of feminism, all over the world."*

Besides, private mental health professionals offered paid services, with generally high fees. Most of the NGOs provided free services, while a few of them were found

to be charging a fee on a sliding-scale basis i.e. depending on the paying capacity of the clients.

These structural factors pertaining to the service provision were found to have a strong influence on the interventions undertaken with sexually abused children and adolescents, primarily in India.

4.4 Conclusions, Discussion and Summary

An overview of the phase-based process model of interventions and therapeutic pathways, as well as the context within which these interventions take place, has been established in this chapter. The following chapters present and discuss each phase of the process model highlighting the interventions and therapeutic approaches practiced by the professionals in India and the UK during each phase, as well as professionals' frame of reference and factors that govern their practice.

Chapter Five

Social Action Framework: Identifying and Releasing the Silenced Child

Breaking the Silence

"The final stroke is often the unheard child and the unfelt child, rather than the disease itself."

(Psychiatrist, Private Hospital 3, India)

5.1 Introduction

Social Action Framework has emerged to be the first key phase of intervention being practiced by the professionals, particularly in India, to address CSA based on their understanding of the cultural factors that push children and adolescents in the 'invisible and silenced' domain. The main goal of this intervention was to break the silence that shrouds CSA, in order to identify and release child and adolescent survivors from the culture of silence and suppression by addressing the factors that prevent disclosures. The social and cultural factors that pose barriers to disclosure of CSA leading to the 'silenced child' are discussed in this chapter followed by the significance, rationale and critique of the practice of the Social Action Framework in India. These findings based on the interviews with the professionals have been substantiated by the review of relevant literature. The chapter ends with overall conclusions, discussion and summary pertaining to the practice of this first intervention of 'Social Action' for addressing CSA.

Social Action emphasises working with families, communities and a larger societal context. Culture can be defined in a number of ways as it has different meanings in different contexts. The definition proposed by Jadav and Jain (2012) from their study on community mental health in India is considered for the purpose of this study. "Culture can be understood as the sum of dynamic beliefs, values and behaviours of a particular group. Thus, culture as a concept can refer both to the community in

which a health care worker works and also to the beliefs, values and behaviours of the health professional and the changing health system (p. 560)".

Most NGO professionals interviewed in India located themselves within a Social Action Framework. A part of the reason attributed by professionals for the same is that the recognition of CSA, including interventions for addressing it, is at a nascent stage in India. NGOs initiated the work on CSA about two decades ago, with prevention and awareness-raising being the key focus. An NGO that considered itself a pioneering organisation in India on CSA work was established in 1996, with a key focus on adult survivors of CSA. It emphasised its genesis within a Social Action Framework in order to create a conducive environment for adult survivors to open up and seek help by increasing awareness and visibility of CSA. This assertion of the professionals has been echoed by the limited literature on CSA from India (Vijayalakshmi & Seshadri, 2001).

> *"I don't see, fifteen years ago, when we started, how that* (therapeutic work on CSA) *could have been possible. I think the only way our services* ***could*** *have started is because it was located in a larger social action framework. Because we also started at a time when there was no awareness of CSA in India and we came in and talked about not only CSA happens but that there are some adult survivors of CSA. So, it could not have happened, actually, any other way. And survivors could not have come in for help if we did not create a social climate to talk about child sexual abuse."* (Founder & Counsellor, Voluntary Organisation 1, India)

Over two decades of inception of work on CSA in India, the trend of social and community-based interventions has strengthened, with a higher number of organisations currently working in this area. Most of the Indian organisations interviewed for the study referred to themselves as 'community-based' organisations.

> *"I would say we work a great deal on community, community awareness, which I would say you know advocacy, prevention, policy. Mental health is very rare and few in between… our work is very community-based. On the whole I will describe when asked, 'Are you individual oriented organisation?' 'Are you community oriented organisation?', I would say community."* (Founder & Counsellor, Voluntary Organisation 2, India)

In contrast, all the agencies interviewed in the UK, both the statuary services and the voluntary sector, primarily have a clear therapeutic focus and remit.

> *"Em, as I said, we are a therapeutic service, so we will see children and adolescents up to the age of 18 who have been sexually abused."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

> *"We provide one-to-one therapy for young people, children or adolescents, up to age of 18 – 19."* (Therapist, Voluntary Organisation 1, UK)

It is inferred from the following extract of a professional from a CSA-Specialist service in the UK that while in India, over the past two decades, the work on CSA was being initiated through 'Social Action' by NGOs to raise awareness and acknowledgement of CSA, the movement in the UK was shifting towards setting up Specialist CSA services within CAMHS to provide need-based therapeutic support to sexually-abused children and adolescents/young people.

> *"It was set up* (brief pause) *maybe 20 years ago, possibly! It was basically set up because the other services em, CAMHS and psychologists were finding that there were some particular cases where there had been abuse and neglect which basically would be on the case load for a long time. Not cases that could be treated quickly and then discharged. So it was kind of to free up the generic service, if you like, and to have a more special service to look at those cases and work with those kids. So that's why it was originally set up."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

Alongside the core therapeutic work, some evidence of Social Action interventions has been found in the UK as well. The professionals' frame of reference that reflects the factors that govern their practice of Social Action Framework as the first phase of intervention on CSA is discussed below. Figure 5.1 summarises the practice of Social Action Framework**.**

5.2. Professionals' Frame of Reference: Cultural Context

While there are universal factors that act as barriers to disclosure for sexually abused

children and adolescents such as threat, fear, shame and guilt (e.g., Alaggia, 2004; London, Bruck, Ceci, & Shuman, 2005; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Paine & Hansen, 2000), the study identified that the Social Action Framework of professionals, particularly in India, is governed primarily by the cultural context. Aligned with the definition of culture (Jadav & Jain, 2012), the cultural context emerging from the study includes the social belief and value system and the structural deficiencies in the mental health system and CSA services. A combination of these social and structural factors has an influence on the professionals' belief, value system and behaviours, and forms the foundation of the Social Action interventions.

5.2.1 The Social Factors: Social Belief and Value System

The social factors reflect the beliefs, values and behaviours of children, families and communities that prevent disclosures of CSA and keep the survivors hidden, unidentified and silent. Three key socio factors have been identified through interviews with the professionals, particularly in India: i. Social ethos of a 'collective' and unrecognised 'agency' of children; ii. Stigmatisation: preserving morality and family honour; and iii. Denial and fear of CSA.

5.2.1.1 Social Ethos of a 'Collective': Undermined Individual Identity and Wellbeing

Professionals interviewed in India attributed the silence around CSA to the culture of collectivism where social norms, family ties and values, and a sense of community take priority over individual needs and well-being. This 'collective orientation and nature' governs social roles, relationships, communications, services, and life in general in India.

> *"We just don't look at these individual sort of thing* (referring to CSA). *I mean, in India… if you look at the kind of context we live in, we are more collective in our thinking than individual in our thinking. And this also, you know, definitely influences the way we perceive self, how we perceive ourselves. Very rarely a person perceives himself as an individual here,*

its very part of the set up." (Founder & Counsellor, Voluntary Organisation 2, India)

Shah and Venugopal (2003, p. 216) quote psychoanalyst Alan Roland who "has talked about the 'Indian Self' as being more of a 'we self', with a radar-like sensitivity." This culture of 'collectivism' or 'togetherness' seems to act as a deterrent for children and families for disclosing and reporting CSA in India.

"This is a difference you will find between the west and India. There, a lot of people eagerly come (referring to disclosure), *because there it is an individualistic society still. We have, despite all individual orientation, which is continuing for the last few decades, Indian people still carry a lot of sense of togetherness. That's why they don't want to come out."* (Founder & Counsellor, Voluntary Organisation 7, India)

The pressures of keeping the family together, fear of hurting or upsetting other related family members or disturbing the relationship-equilibrium in the family seem to become emotional barriers for families to disclose CSA especially in cases of intrafamilial abuse.

"The aunt's husband has been abusing her (referring to a nine year old sexually abused girl), *so there are lots of social issues, which were involved. And uh the parents were in a dilemma as to whether to reveal this to the aunt or not because she is father's sister, real sister. The brother and sister were very close to each other."* (Psychiatrist, Private Practice 1, India)

Following the same legacy, children in India also feel the burden of maintaining normalcy in the family environment, given the close-knit family structure including extended families.

"Second cause of guilt was, it was her aunt's (referring to father's sister) *husband. So if the aunt came to know about this, what would be the repercussions!!* (Psychiatrist, Private Practice 1, India)

This social ethos of a collective to a large extent governs the attitudes and belief system of the professionals themselves and consequently, the interventions undertaken by them. Professionals seem to accept that parents and other adult family members are the 'gate keepers' and have prime authority over children. The

"agency" or individual identity of the child is unrecognised and under-valued. Decision-making in matters concerning children, including their mental health needs, lies with the families and communities.

> *"We look at it more in terms of receptivity by the family because the child has really no agency in these situations* (referring to CSA). *So it has to be a family decision. It's actually the family which decides."* (Founder & Counsellor, Voluntary Organisation 2, India)

Lack of "agency" of children is reflected in the reaction to their disclosures by family members and/or other significant adults. Children are often met with denial and disbelief, and sometimes physically reprimanded, when they disclose abuse particularly by an adult family member or acquaintance. Adults enjoy greater trust and acceptance within families than children. Hence, interventions for enhancing the receptivity of parents are considered critical for facilitating trust, belief and support towards child's disclosure of CSA.

> *"I think the first reaction many times we have come across is the child is often slapped. The child is often reprimanded, 'How dare you say that this could have happened to you by this uncle or this cousin?'* (Psychiatrist, Private Hospital 3, India)

> *"When she* (referring to a 9 year old girl) *shared with the mother at night, mother says, 'Look, don't talk like this, how it happened, because he's such a nice boy and such a good boy (referring to a 21 year old family friend who sexually abused the girl).'* (Founder and Counsellor, NGO Practitioner 6, India)

Even when the children are believed, they are blamed and considered responsible for self-protection from significant adults who abuse them. The adult abusers are absolved of their criminal responsibility of sexually abusing a child, implying that adults have a more significant position in the society, even those who are abusers.

> *"We see that the parent would start blaming the child or somebody else would start blaming the child. Like aaa suppose the mother will tell that 'you should not have stayed in that space or you should not have got so close to that particular person so that person had taken an advantage'."* (Psychiatrist, Hospital 2, India)

In addition to the trauma of CSA, finding oneself amongst unsupportive parents and living in close proximity to the abuser are considered to be the inevitable consequences of 'keeping the family together' and 'lack of agency and belief in the child'. Not only it enhances the trauma in children, it further compromises their safety, adversely affects their relationship with parents, and pushes the child further into an isolated shell.

> *"I mean it's very very confusing to the child... we find it actually creates a lot of displaced anger, create a lot of dismissed anger because there is no closure where the family is dealing with the abuser. It's all very grey. Because how do you say? How do you deal with grand old patriarch of the family, though you know he is the abuser, fine you may be a little more careful but then you still allowing this person to come into your house, the child can't understand what is happening. Next time it happens, you cannot talk about it."* (Founder & Counsellor, Voluntary Organisation 2, India)

At the primary level, interventions with the families are perceived to enhance their receptivity to CSA. Further, it is expected that it may also lead to greater openness of families towards the need for therapeutic support for the child by making parents aware of the multiple issues that the child seems to be dealing with. These include feelings of "displaced anger and confusion" due to the lack of support from the family and having to accept the abuser as part of the family. Presumably, it also has the scope of improving family relationships that may have been affected due to CSA or prior to that, hence keeping the social ethos of a 'collective' intact while enhancing the "agency" of the child within the family.

The above factors of 'collectivist thinking' and 'lack of agency and identity of children' were reiterated by professionals working with the ethnic communities in the UK, primarily Asian/South Asian communities. In addition, dilemmas and conflict associated with 'cultural identity' were viewed as additional barriers to disclosure for children from the ethnic minorities.

> *"There is also I believe there are cultural identity issues. I think the biggest that comes up for us within the young people work, issues that we*

see every week, is cultural identity… They can either be born here in the UK or be a migrant, and they are having to manage you know, their culture, their roots of culture as well as the new culture they have moved into. Girls from ethnic minorities are little more introverted, they are watching what they are saying and disclosing." (Case Worker, Voluntary Organisation 4, UK)

5.2.1.2 Stigmatisation: Preserving Morality and Family Honour

Another cause of silence that drives Social Action interventions is the stigmatisation of CSA due to the taboos around the issues of sex and sexuality. Talking about sex, including sexual abuse, is embarrassing and shameful, not only for children but also for parents. Upholding the virginity of girls is considered highly significant and is linked with preserving the family honour and pride. Due to any sexual involvement prior to marriage, voluntarily, involuntarily or by force, girls are regarded as perpetrators of a crime rather than the victims.

"First she (referring to child) *gets denial, ignorance. Then she* (referring to the mother) *says, 'Look, now you keep mum; in the name of the family, we need to. Otherwise, your father will come to know; you will not get married. Nobody will accept this societal issue.' And this all creates further stress and adds on to the trauma of the person. Where to go?"* (Founder & Counsellor, Voluntary Organisation 6, India)

This fear of sigma and anticipation of its negative impact on the family honour and marriageability are considered to be a cause of strong negative reactions of denial, shame and shock in parents on learning about the sexual abuse of their child, especially in case of a girl. It is speculated that perhaps blaming the child for the sexual abuse helps the parents deal with it better. It is possible that since parents are considered to be the sole protectors, primary care-givers and gate keepers of the child, with child having no agency, they may feel guilty (especially mothers) for not protecting their child. Projecting their feelings onto the child may help detract their feelings of responsibility and guilt.

"Parents were initially shocked, as I said. They were completely devastated. You see it's the typical Indian mentality you know when it comes to sexuality, you know how things are in India, right! So the

> *acceptance wasn't there at all, in the first place. They were blaming the girl. You must be doing something."* (Psychiatrist, Private Practice 1, India)

On the other hand, the projection of their fears linked with sex and sexuality may trigger over-protective reactions and judgment from parents towards the child. For example, a mother approached a psychiatrist from protecting her child from getting "habituated" to sexual activities.

> *"The other one was, 'I hope he's not started enjoying it', because they* (parents) *were seeing that the child was fondling with their private parts and things like that. 'Now that it has happened, I don't know what to do' and 'I hope he hasn't started enjoying it and makes it a habit. So, I'm very, very cautious, I don't leave him alone."* (Clinical Psychologist, Private Hospital 3, India)

In both the above scenarios, the enormous impact of CSA on children is not understood by the families and a tendency to stigmatise and label the child is evident. Such taboos and pressures on children were also discussed by the professionals working with ethnic minorities in the UK too. It indicates that these socio-cultural factors are so deeply internalised that they seem to persist beyond geographical boundaries.

> *"Let's use a really really simple example you know like, em like talking about your menstrual cycle. Em it's not even spoken about within the household. I think at school they have received education but you know a lot of girls and women see it as dirty. So if there are issues internally, on a gynaecological level, then they are not going to speak openly, and if there is something going on sexually or if they are exploring sexually, em they are not going to share that because on a cultural level, it is not okay, it's a taboo."* (Case Worker, Voluntary Organisation 4, UK)

The above findings about secrecy, shame and stigma around issues of sex and sexuality are consistent with other international and national studies from India (Fontes & Plummer, 2010; Giligan & Akhtar, 2006; Purewal, 2003; Stoltenborgh et al., 2011). Both positive and negative experiences of sexuality are addressed and internalised based on "myths, misconception, misinformation, social conditioning, pornography and/or skewed media depiction"; and as a result "the blocks {to

disclosure} become that much more difficult in the transition from general sexuality, to sexual abuse to child sexual abuse (Vijayalakshmi & Seshadri, 2001, p. 248)". Vijayalakshmi and Seshadri argue that stigmatisation is considered to be a predominant dynamic underlying abuse and its disclosure.

Hence interventions with the families and larger social system are considered imperative by the professionals to facilitate understanding of child's disclosures of CSA without the fear of being judged and/or stigmatised. For example, referring to the traumagenic dynamics conceptual framework of Finkelhor & Browne (1985), a practitioner in India emphasised their work with families and communities to address stigmatisation. The traumagenic dynamics conceptualises the impact of CSA based on four trauma-causing factors - traumatic sexualisation, betrayal, stigmatisation, and powerlessness.

> *"More often than not, we you have to address stigmatisation because the other three are very individual, whereas stigmatisation is about the whole family. Get over the whole stigmatisation around abuse really, not even look at the other ways in which it affects the child."* (Founder & Counsellor, Voluntary Organisation 2, India)

5.2.1.3 Denial and Fear of CSA: Under-Acknowledged Existence of CSA and its Impact on Survivors

Lack of acceptance, stigmatisation and discrimination of sexually abused individuals is also attributed to the lack of awareness of CSA in India. Thus, 'Social Action' for awareness-raising is considered to be an imperative first step for facilitating acceptance of its survivors.

> *"There is zero acknowledgment of something like this* (CSA). *Or from zero, now after fifteen years* (referring to the time since the inception of this NGO)*, it's moved to ten to fifteen, twenty percent."* (Founder & Counsellor, Voluntary Organisation 1, India)

Due to lack of awareness and information, professionals argued that the impact of CSA on children is not understood by the families and communities. The reason for low awareness of CSA and its impact on survivors was further ascribed to the

nascency of interventions, which also makes it challenging for the professionals to work on this issue.

> *"And given the stage that child sexual abuse work is in India, I feel that a lot of people simply do not have enough information and knowledge of very nuanced understanding of underlying dynamics of how sexual abuse is happening and how it affects children. And what other abuse-created dichotomies, what happens to the mind of a child, what is really happening to the child when she is being sexually abused or post sexual abuse"* (Founder & Counsellor, Voluntary Organisation 2, India)

Partly, the challenges for working on CSA also stem from the lack of awareness and understanding of CSA even among the professionals leading to a lack of comprehensive and informed services, including prevention as well as treatment interventions to address CSA in India.

> *"There is a lot of mysteriousness about how it happens, why it happens and who does it, and what are the best ways to bring about a remedy for this, prevention for this, intervention and maybe even treatment for people, young people, very young people, very young children who suffer in silence."* (Psychiatrist, Hospital 3, India)

Inadvertently the therapeutic needs of children are ignored. Even in cases where the child is brought in for therapy, high attrition rates were reported due to lack of awareness, and consequently low priority accorded to therapeutic interventions by families. Drop-out from therapy was also noted by professionals in the UK, however the concerns were associated with therapeutic challenges.

> *"I would say only ten to fifteen percent of the population would continue and would end it* (referring to therapy) *you know, that's because probably the acceptance of the entire discipline and the work that we do is still at a very nascent stage."* (Clinical Psychologist 2, Hospital, India)

On the other hand, professionals recognised that some parents feel extremely distressed on learning about the sexual abuse of their child but are unable to seek help due to the lack of awareness of CSA as well as services available to deal with the same. This reflects the need to create awareness and opportunities for families to seek help for their child and themselves.

> *"Most often, the revelation is already there at the family front, and they know about it... they are obviously shattered and they don't know and they look for how do you deal with the child… so that the child does not suffer."* (Clinical Psychologist, Hospital 2, India)

While on one end of the spectrum, there is complete denial of CSA and its impact, on the other end, people react with fear. The latter is considered to be fuelled by the exaggerated reports by the media. Both these reactions were attributed to the lack of education and proper awareness of CSA and nascency of interventions.

> *"It's like, on television, you'll see 'Oh, monster father', you know! It's of course, that's the media and the way they talk about it, but there's a similar approach, that 'Oh my God', and that comes from a lack of understanding of child sexual abuse as a phenomenon of it."* (Founder & Counsellor, Voluntary Organisation 1, India)

Low level of awareness on CSA poses challenges for the professionals in the UK as well. Even though there are multi-disciplinary teams and services in the UK to address CSA and overall child protection issues, not always all the teams were considered to be fully aware of it and its consequences for children. Hence, all CSA-Specialist agencies including CAMHS CSA-Specialist services and VOs also undertake interventions with these teams to educate them on CSA.

> *"In our culture, some of the things we come up against that make our work more difficult, for example, with a child. We might be thinking, 'In our work, this is what we're doing.' And then when we go outside to try and explain it to some other people, maybe a social worker or schools, it's almost like we are talking a different language, so we have to be very, obviously, good at explaining in normal words what's going on for the child, and we need to pass on the information."* (Therapist, Voluntary Organisation 1, UK)

Similarly, lack of understanding of CSA and benefits of therapeutic support are considered to be deterrent for reporting and seeking services by the survivors and their families from the ethnic communities in the UK. This lack of understanding seems to create challenges for the professionals to reach out to people in ethnic communities and provide appropriate support to them.

> *"One of the barriers is, with therapeutic support, counselling, em we notice there some anxiety of trust may be and not knowing and understanding what it might bring them and would do for them so lot of times they say no quite a few times, at quite a few levels. Em, so lot of times, it's just figuring out how we can support that person."* (Case Worker, Voluntary Organisation 4, UK)

The findings of this study regarding social factors are consistent with other literature. Disclosure of sexual abuse is reported to be affected by cultural factors and barriers (Fontes & Plummer, 2010) including fear of negative reactions from the family; lack of support from families; issues of sex and sexuality (Futa, Hsu, & Hansen, 2001; Paine & Hansen, 2000); collectivistic value orientation; attitude towards family structures including structured roles and norms for children within the family; power dynamic within families and communities; and values of maintaining harmony, self-restraint and conformity; and family honour and clean reputation (Futa, Hsu, & Hansen, 2001; Rinchin & Maitra, 2001; Vijayalakshmi & Seshadri, 2001). Further, studies from India emphasise that rigid and discriminatory patriarchal culture and social norms perpetuate disbelief, secrecy and stigma on victims of CSA (Gupta and Ailawadi, 2005). Such perceptions and cultural barriers around sexuality and patriarchy are known to prevent disclosures and make children more vulnerable to CSA (Rinchin & Maitra, 2001).

From the above analysis of the social factors, it is evident that in the existing social and culturally restrictive situations in India, and in some situations in the UK, professionals consider child and adolescent survivors of CSA as 'silent sufferers'. This ongoing silent suffering is recognised to cause additional layers of trauma in addition to the sexual abuse experienced. Thus, through Social Action, professionals attempt to free children of this "suffering" and "injustice".

> *"The fear of disclosure in girls is so high that at times it is worth suffering it, rather than disclose it. So, who lives in fear? Only the people who probably know that they cannot talk about this to anybody. And if they grow up like this, I think they are doing a lot of injustice to children because they grow up with the idea that if they talk, they will be*

condemned or denied or maybe put to disadvantage." (Psychiatrist, Hospital 3, India)

5.2.2 Structural Factors: Deficiencies in the Service Provision and System

As pointed by Jadav and Jain (2012), culture includes the health system within which the health workers function. A number of structural deficiencies within the mental health system in general and specifically for the survivors of CSA (both adults and children) have been emphasised by the professionals that form the basis for the Social Action Framework. Structural factors that have been identified based on the responses of the professionals primarily in India include the deficiencies in three key domains: i Statuary provisions; ii. Therapeutic service provision; and iii. Qualified and skilled MH professionals and CSA-therapists. Some gaps in the therapeutic services have also been identified in the UK.

5.2.2.1 Missing Statuary Provisions and Policies

Statuary guideless, protocols, policies, or legal obligations for mental health care and psychological provision in India do not exist in general, and in particular for sexually abused children and adolescents. The issues of CSA in particular and violence against women and children in general, are not considered to be a priority for the government in India. There are no government schemes, policies and resource or budget allocation for the mental health services for sexually abused individuals and their families.

"There is no focus as such, even in the law, uh, there's no focus on that (referring to MH interventions for sexually abused children). Maybe it's resource driven, that's why, I think, the state has not been serious about it, because for hospitals, the priority has been life threatening, you know. So rape victim is not a priority, the mental health aspect hasn't drawn much attention in terms of providing services." (Founder & Counsellor, Voluntary Organisation 5, India)

With recent legislative developments in India including POCSO 2012, mandatory reporting of harm and certain legal and witness protection provisions have been put

in place for sensitive legal trails and proceedings. However, mental health or therapeutic services for child and adolescent survivors of sexual abuse have still not been considered, which was confirmed from the provisions of POCSO and was reiterated by the professionals.

5.2.2.2 Limited Therapeutic Service Provision

Mental health and therapeutic services in general, and in particular for CSA are found to be limited in India, within all three key sectors including the government/statuary services, NGOs, and the private sector including hospitals and independent mental health practitioners. To the knowledge of the researcher, the sample for the study covered most of the groups working on CSA in India including NGOs, hospitals and institutions, and private practitioners specifically catering to sexually abused children and adolescents. All these groups are situated in major states of India, which indicates that the CSA-specific services are missing in a number of states and smaller towns of India. This was confirmed by the professionals in the study.

> *"We are looking at things that simply do not exist. It's not that a few services exist, they do not exist. And then, there are 2 or 3 or 4 people doing something about it."* (Founder and Counsellor, Voluntary Organisation 1, India)

Physical infrastructure and human resources to deal with mental health needs of people in general, and specifically for CSA survivors are limited in government-run hospitals and institutions.

> *"In government hospitals, what is the mental health set up? We have a psychiatric department which deals with, it's not child specific. Even this substance abuse and drug addiction among children, it has not been a concern for the government. Most of the government hospitals, there's an OPD* (out-patient department) *facility, not even, you know, hospitalisation for children. So, all that is lacking, in terms of infrastructure, both physical and human resources."* (Founder and Counsellor, Voluntary Organisation 5, India)

Hence, the NGOs took on the responsibility of initiating work on CSA in India. Most of the NGOs that work on CSA have their genesis in the feminist paradigm, with a focus on Social Action including prevention and awareness-raising on CSA (and other issues of violence against women and children).

> *"It's actually NGOs who started the trend* (referring to the work on CSA), *to be very honest, because they, in any case, violence work and CSA work has come because of feminism, all over the world. It has started because of feminists and I think that trend somehow continues."* (Founder and Counsellor, Voluntary Organisation 1, India)

Confirming the above sentiment, Purewal (2003, p.230) states, "we found that except for the few on the road of feminist empiricism, most people preferred to live in complete denial." Social Action is considered to be an offshoot of a feminist orientation, where questions of social power, discrimination and gender-based discrimination are constantly questioned, and interventions focus on permeating through the walls of denial and silence that shrouds these issues. This focus of the NGOs seems to have strengthened and continues after two decades of initiation of interventions in this field of CSA in India. As a result, the Social Action interventions seem to have gained moment while the professionals face challenges in meeting the therapeutic needs of survivors due to lack of therapeutic services.

> *"Sometimes, if a teacher approaches us* (with a referral for CSA), *often, actually, there is nothing we can do. Often, we have to say there is nothing we can do on this, because even as an organisation, we can't stretch ourselves for every individual case, one way... And with the lack of systems to handle this, it becomes a big struggle for us to be able to respond to every case that comes up."* (Founder and counsellor, Voluntary Organisation 1, India)

Therapeutic service provision and access is further affected by financial constraints. Free of cost services are provided only by NGOs in India. This was seen as one of the challenges for making referrals for therapy to mental health professionals in private practice including hospitals and independent practitioners.

> *"The availability of the resources is very wanting. We are always struggling with who to refer a child to, where somebody doesn't have to*

> *pay a lot of money, because one is the individual therapist where only very few people can go. But in terms of a centre, where somebody will take in a child, which may or may not be free but will be low cost, is really tough to find. I can't think of a centre that one would refer to. But the spaces are too few, very, very few."* (Founder and counsellor, Voluntary Organisation 1, India)

This aspect about 'paid service' was acknowledged by a Clinical Psychologist associated with a private hospital as being a barrier for parents in accessing their services or continuing therapy. She confirmed that the insurance in India does not cover expenses towards psychiatric help or therapeutic support.

Further, mental health professionals who are trained in therapeutic practice were seen to usually work in private hospitals and/or private practice. They were criticised by NGO professionals for their lack of willingness and interest to work with victims of violence in particular and specifically with sexually abused children. Further, a number of professionals from NGOs were also critical of the mental health professionals for their heavy reliance on medical models or medical diagnosis without cultural adaptation.

> *"Mainstream people* (referring to the mental health professionals) *are just happier making their money or setting up their practice or they are getting into individual practice, they have no concept of community mental health, forget about working with violence."* (Founder and Counsellor, Voluntary Organisation 4, India)

> *"There doesn't seem to be any cultural competence or relevance to the work which is being done. Absolutely, I mean it's just like, not even looking at adaptation of models. It just seems to be like straight copycat kind of a situation. It is just too threatening; we have to look at the socio-cultural dimensions also."* (Founder and Counsellor, Voluntary Organisation 2, India)

Finally, it is inferred from the study that the structural deficiencies are further enhanced due to the lack of coordination, partnership, interface and harmony between two key sectors engaged in CSA work in India: the NGO sector and mental health professionals in hospitals and private/independent practice. Their services seem to be diverse, disintegrated and fragmented and isolated.

> *"There is no interface, there is no interface. No, because the… NGOs who specialise in the abuse cases, they would have their own psychologists and all that for dealing there. So there is no interface, because NGOs, they are working in a self-sufficient way."* (Clinical Psychologist, Private Hospital 1, India)

The NGO sector in India was found to be by and large critical of mainstream mental health professionals, due to challenges with high fee structures, adherence to medical and western models, and lack of expertise and integration of trauma or violence in their work. At the same time, the mainstream mental health sector often seems to be working in isolation without engaging with the NGO sector. Two examples of successful joint working and partnership between the mental health professionals and NGOs were found, which indicates that they can yield quicker and positive results by working in collaboration. One of them focusses largely on improving socio-medical and legal practice (discussed in the following section on 'Social Action' interventions). The second is an example of collaboration for improving therapeutic practice by an NGO through collaboration with two independent mental health practitioners/therapists (discussed in following chapters). These two examples indicate that better, more accessible, and locally-based service provision is possible when these two sectors work together in close partnership, however this seems to be largely lacking within the current service system.

Structural deficiencies such as the lack of culturally sensitive therapy provision and dissatisfaction with the mainstream agencies (such as the social work and CAMHS) were expressed by professionals working with the ethnic minority communities in the UK as well. This seems to be consistent with the review of service provision for sexually abuse children and young people in the UK, where these gaps for ethnic minorities were identified (Allnock et al., 2009).

> *"There isn't enough… language speaking counsellors..., Lots of counsellors and agencies are working on the child protection but when it comes to culture, tradition, em community, you know…, that's where the barrier comes. So, there needs to see more counsellors especially with the language and with the understanding of the culture and tradition."* (Therapist, Voluntary Organisation 5, UK)

"We have many a time felt let down by the mainstream services due to the cultural issues, or cultural sensitivities." (Case Worker, Voluntary Organisation 4, UK)

5.2.2.3 Missing Skilled MH professionals and CSA-Trauma Therapists

Lastly, the structural deficiencies include the overall lack of expertise and skilled therapists in general and specifically for CSA-trauma therapy.

"I would put it that people who are providing counselling, there is a serious problem for quality in counselling. Now in the name of counselling, what we are seeing that 70-80% of people who are engaged as counsellors lack basic skills. But counselling as such… you know, dealing with the individual, their personality, understanding their personality, looking at the dynamics, the problems within family, these counsellors are not equipped with those skills, at present, most of them." (Founder and Counsellor, Voluntary Organisation 5, India)

Overall expertise in the field of trauma therapy was reported to be low. It was partly attributed to lack of CSA or trauma education in academic curriculums and partly to the nascency of trauma work including CSA trauma interventions.

"I've seen that, dealing with CSA and maybe other forms of trauma, even trauma therapy is new in India, other forms of trauma, even traumatic experiences are not dealt with properly. Very few people will say that they are trauma experts." (Founder and Counsellor, Voluntary Organisation 1, India)

Lack of trauma therapists was also noted by professionals in the UK. While most of the CAMHS services (Tier 2-4) have trained mental health professionals, those associated with the Generic services (Tier 2) were critiqued for their lack of expertise in trauma work or identification of CSA trauma.

"I have also had some children that maybe were referred to me as a general psychologist, before I actually started specialising. And, to be honest, probably we missed the fact that they'd been abused and then they come back later on, when they've got enough confidence to actually admit that there was an abuse or we find it out and then you start working with them, perhaps in a different way." (Clinical Psychologist 2, CSA-Specialist Service 1, UK)

In the UK, this gap is accommodated by CSA Specialist services. While in India, this research suggests a need for CSA-trauma therapy specialists, at the same time in the UK, reduction of these specialists has been noted as a challenge by all the professionals interviewed in these services. Lack of financial resources and budget cuts is leading to reduction of trained therapists in the CSA-Specialist services in the UK.

> *"We have lost clinicians that haven't been replaced, I guess just because of the way things are at the moment economically. Em we could do with more bodies, really, more people on the team because we have quite a big team but a lot of us work part time, so in terms of quota equivalent… it's not that high."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

This implies that both in India and the UK, there is a current need for higher number of trained CSA-trauma therapists. CSA-specific training for the professionals has been emphasised in both the countries to ensure better therapeutic provision for survivors. Besides, a need for better education and training in psychotherapy in general and a regulatory body for licencing of counsellors or psychotherapists in India have emerged from the interviews with the NGO professional in India.

> *"None of our teaching courses are adequately addressing CSA in their course materials. They're not giving it the importance that is required and they're not dealing it into. How can you actually have mental health services or treatment or any training for it without firmly putting CSA in the curriculum?"* (Founder and Counsellor, Voluntary Organisation 1, India)

> *"It's not recognised, there's no kind of body which regulates this counselling profession, like you have for doctors. Who is fit to be a counsellor? Who's qualified to be a counsellor? So the certification, the licensing, those things are absent."* (Founder and Counsellor, Voluntary Organisation 5, India)

Lastly, working on sexual trauma issues with children was considered to be difficult and challenging, at a personal and professional level, by most professionals in India and the UK. This causes additional challenges for professionals in India, as there is no support available within the social or service system to deal with burn-out and

impact of trauma work on them. Most CSA-focused NGOs seem to be working in isolation due to the structural and systemic deficiencies. This is presumed to add to the pressure on already minimal services and limited professionals in this field.

> *"And I think that's very trying on organisations that are doing this* (work on CSA)*. It's a big struggle to keep afloat; to not get completely burnt out. Of course, we are all burnt out at different levels and we all then pull ourselves together, but to be able to keep the faith and continue to work is very, very tough. And that comes from this larger lack of support through policies, through systems, through social understanding of violence and abuse of women and children."* (Founder and Counsellor, Voluntary Organisation 1, India)

Except for peer-support and mentor-support provided by two agencies to its professionals, the study identified that, unlike in the UK, most of the agencies working on this issue in India do not have systems built in to recognise and address the impact on the professionals associated with them.

> *"There are very few organizations who realise the whole mental health component and there are very few organizations who had workshops for frontline workers, you know, working in trauma and violence in terms of their own healthcare and vicarious trauma."* (Founder and Counsellor, Voluntary Organisation 2, India)

Although it was not verified if stress and burn-out caused due to vicarious traumatisation causes staff attrition and leads to further deficiencies of professionals in the field. Most of the NGOs identified had small teams and the professionals/therapist interviewed from these NGOs were the founder-directors themselves who continued to work on CSA for over a decade or more. At the same time, some professionals, both in NGOs and hospital/private set-up, shared personal strategies devised to deal with their stress. Perhaps these are the reasons that help them continue their work on CSA besides feeling the burn-out, stress and vicarious traumatisation.

> *"A few times it happens that we feel we can't carry more, we have our own break. For example, in 2005, I had, in two months, handled nine suicide cases. For another three months, I didn't do any counselling*

because I feel so much after handling." (Founder and Counsellor, Voluntary Organisation 6, India)

5.2.3 Personal Belief and Value System of Professionals

The health worker's or professional's beliefs, values and behaviours are also considered to be a component of the concept of culture (Jadav & Jain, 2012). Based on a number of reflections and observations, it is speculated that the professionals' personal beliefs, values, perceptions and/or skills also contribute to the greater practice of Social Action Framework as well as the lack of therapeutic interventions for child and adolescent survivors of CSA in India.

First, lack of therapeutic services and expertise can perhaps be attributed to the lack of expertise, interest and/or priority of some professionals themselves for setting up therapeutic services. Although some of them have set up NGOs for addressing the cause of CSA, quite a few prioritised working with families and communities based on their perceived demand and receptivity for services.

"So very few people believe there is need for mental health intervention. And we refused to invite ourselves for the party." (Founder and counsellor, Voluntary Organisation 2, India)

Although the professionals were candid about the lack of qualified and skilled CSA and trauma therapists in India, this was observed by the researcher as well during the interviews with them for the study. It was noted that most of the NGOs lack qualified trained counsellors and therapists, specifically in trauma therapy but also in basic counselling skills. Mostly, founders of the NGOs themselves were found to be engaged in providing emotional support and advise (which some of them termed as 'counselling'), without having any training in counselling and psychotherapy. An example of this was observed in a case narrative of a telephone counselling situation with an adolescent survivor of CSA which suggests advice-giving and guidance rather than psychotherapy.

> *"I told her, 'I can assure you, where we are living, the human society is full of vultures. And the best way to get away from this is to inform yourself. And since you are getting a good education in a good college, you pursue. I know this is not easy. You think in that direction, how can you excel in your studies, how can you do better in the programme, if you have a good record of academics, so tomorrow, you can go abroad, also, you can get a scholarship, many things. And I gave her a lot of ideas about scholarships."* (Founder and Counsellor, Voluntary Organisation 6, India)

A number of examples of this nature were identified through sharing of case narratives by professionals, in both one-on-one and telephone counselling situations. Personal biases and discomfort of some of the professionals themselves around the issues and language of sex and sexuality were also observed through their responses. These observations indicate that some of the professionals themselves are entrenched in the same socio-cultural barriers and biases around the issues of sex and sexuality as the families and communities. For example, one clinical psychologist from a private hospital referred to sexual abuse as "this thing", "it" and/or "this activity" throughout the interview and a number of pauses were observed in her speech when she attempted to explain any phenomenon associated with sex or sexual abuse. This indicated her discomfort in talking about sexual abuse. Another example is reflected in the language used in the following excerpt to explain sexual abuse experienced by some girls seeking help from the NGO with which this professional was associated. There seems to be an implied meaning of 'damaged goods' in the following words, a derogatory term often used for survivors of sexual abuse.

> *"There is one girl who says she is used by her friends and then her stepfather has been using her aa and there are 2-3 girls who are used by their own people. One girl was used by her own brother and then by the friends."* (Care worker, Voluntary Organisation 4, India)

Other words and phrases such as *"virginity being snatched"* or "*children seeking stimulation*" were noted where a sense of judgement or blaming the survivors was apparent. These instances reflect an internalisation of the social and cultural prejudices and stereotypes that could possibly influence their practice with sexually abused survivors. These are the very notions and beliefs held socially and culturally

that may stop survivors from disclosing sexual abuse. These factors point towards limitations of the counsellors and care-workers with understanding and expertise in CSA-trauma therapy in these organisations, possibly leading to the lack of therapeutic services for survivors of CSA.

On the other hand, a number of extracts included earlier in the chapter reveal that the quite a few professionals recognised the multiple layers of trauma experienced by children and adolescents due to CSA and post-CSA adjustments and reactions of families and communities. Consequently, they argue for a need for therapy for child and adolescent survivors of CSA. However, for them, the Social Action Framework seems to be the process of adjustment to the current socio-cultural situation in India to ensure prevention of CSA and protection of children and adolescents from it.

> *"It is always good if a child can go into formal counselling; but if the child cannot, and in places like ours, you have to work with what you have. Then the next best option is to really empower the adults around the child to at least not make a mess of it."* (Founder and Counsellor, Voluntary Organisation 1, India)

To conclude, it is evident from the above analysis that the Social Action Framework is a consequence of and a response to the social and structural challenges faced by the professionals in India, which influences their own beliefs, value system and behaviour. These challenges were aptly summarised by an NGO professional by drawing an analogy of the field of CSA in India with a "war-zone", both for the practitioners as well as the survivors. The sense of isolation and helplessness due to the cultural factors is apparent in the following excerpt.

> *"Then dealing with prejudices, with biases, the usual social stuff. You're actually working in a battlefield. Your client is in a battlefield, you are working with a war zone over there because she is (referring to a sexually abused female) emerging or has been in a battlefield and is trying to emerge, or is currently still in a battlefield. If it's a child, further in a battlefield; even adult survivors are in a war zone, even back home, where nobody is understanding. So, you are working in a war zone, really. And you are working in isolation, with the few systems that you have created, with small referral networks that you have created, because you simply need to create them and you have created them as you have*

gone along because nobody has taught you that." (Founder and Counsellor, Voluntary Organisation 1, India)

At one level, Social Action seems to be the process of adaptation to these challenges faced by the professionals. At the same time, Social Action interventions are a response to these challenges as by working through this framework, professionals aim to bring about social and structural changes with the main goal of 'breaking the silence' around CSA. NGOs appear to work towards getting the issue of CSA recognised within the larger "mainstream" sectors, for it to be acknowledged and prioritised through the 'Social Action Framework' in India.

While some professionals believed that there is a need for mental health and therapeutic services to guide and support sexually abused children and adolescents, they argued for these to be situated within the socio-cultural context.

"I mean individual mental health is a very alien concept in India. You look at the average Indian, okay, the kind of population right across the country, rural India etc., you know, urban metro India, mental health intervention is essentially a very community, family supportive kind of intervention." (Founder & Counsellor, Voluntary Organisation 2, India)

5.3 Social Action Framework Phase: Key Interventions

Four key areas of interventions were identified under the core category of the 'Social Action Framework': i. Child and adolescent focussed interventions; ii. Joint child and family interventions; iii. Family-focussed interventions; and iv. Community-focussed interventions.

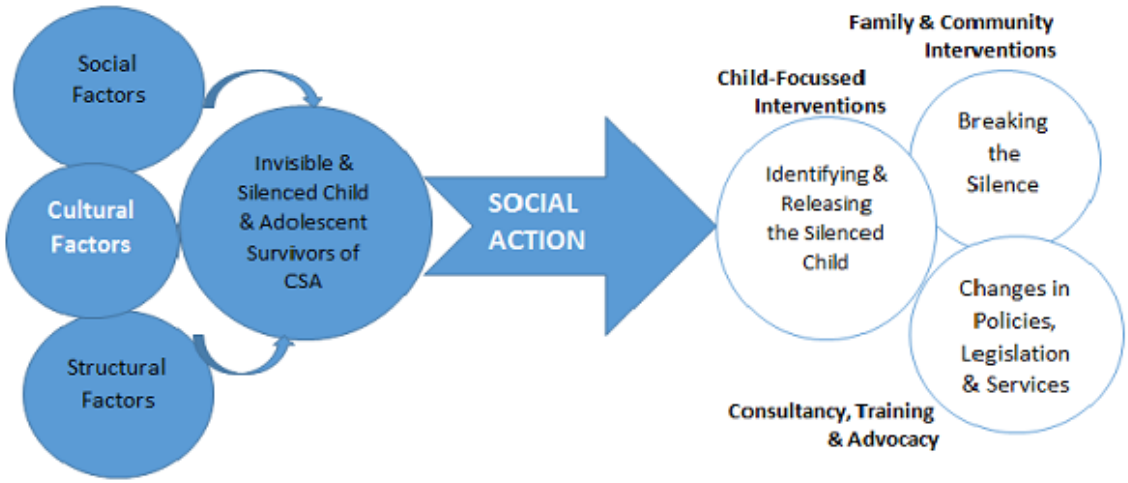

Figure 5.1: Practice of Social Action Framework

5.3.1 Child and Adolescent Focussed Interventions

5.3.1.1. Personal Safety Education and Sexuality Education

The main focus of these interventions is to facilitate disclosures by educating children on issues of sex and sexuality including providing them appropriate language and enhancing their comfort for talking about these issues. Professionals provided evidence of increased disclosures CSA as an outcome of these interventions.

> *"We started modules, we started talking to high school children and then went on later to more details. But then in the process of sexuality education, lot of kids started coming up with, uh, issues about sexual abuse and that's when we realised that's a huge issue that we have to look at. And then parents and teachers would call us up and say, you're talking about sexuality, this is what's happened to my kid or this kid I know, what do we do? So, we got into child sexual abuse."* (NGO Practitioner 3, India)

For some organisations, sexuality education with children and adolescents is a first step through which CSA issues are raised and discussed. Other organisations undertake direct awareness raising and discussion of CSA with the key aims of prevention and identification of children with sexual abuse experiences through Personal Safety Education (PSE). For only few organisations, this education leads to further therapeutic interventions. Others may facilitate referrals to another professional for therapy, however challenges in doing so have been emphasised earlier. Above all, PSE is about engaging and empowering children for facilitating protection from CSA and encouraging them to speak about it.

> *"We start explaining to them once they start going to school and at every stage, we tell them about the good touch and the bad touch and the lines which they need to draw."* (Clinical Psychologist 2, Hospital, India)

At the same time, PSE or sexuality education in isolation was not considered enough to provide the necessary support to sexually abused children. An over-emphasis on PSE in isolation was criticised.

> *"I find it problematic that we believe that it* (PSE) *is the panacea to all problems and that it can help a child actually from being abused. People say that PSE can give children a notion about their personal safety and probably allows disclosure faster if it happens. I mean I can have a problem you know saying that we empowered four thousand children over the year.in protecting themselves. That's baloney to me. Because I mean just because you give children notions of their protection doesn't mean they can actually stand up to an abuser."* (Founder and Counsellor, NGO Practitioner 2, India)

However, most professionals from India supported these interventions. Current research also suggests that the likelihood of disclosures by children increases through sex education (Fontes & Plummer, 2010), as it takes away the shame, silence and secrecy. Alongside other interventions to create a supportive environment to facilitate disclosures and decrease possible negative reactions when children tell are considered important to educate parents, carers and other professionals working with children, both by professionals in the study and empirical literature (Paine & Hansen, 2000).

Based on the responses of the professionals, outreach of PSE or sexuality education seems limited. All but one of the professionals described how these programs are largely carried out with adolescents reaching puberty, usually in schools, which may exclude large numbers of younger children who are highly vulnerable to CSA. Second, it leaves out a larger number of children who do not attend school or are school-dropouts, which is significant in India.

Similar interventions of educating children and adolescents were noted in the UK as well, particularly by those voluntary organisations working with ethnic minority groups who run support groups for young adolescent girls. Their main aim is to harness support by bringing together girls struggling with similar issues.

> *"It gives courage and confidence in its most simplest form… and I think if you have the courage and confidence and self-awareness, self-worth, em things seem a little more lighter and brighter to challenge possibly those injustices that you may be facing and knowing that there is support available."* (Case Worker, Voluntary Organisation 4, UK)

5.3.1.2 Telephone Helpline/Counselling

Providing initial emotional support and guidance through telephone helpline is considered a form of the first level crisis intervention, specifically for children and adolescents. An NGO professional operating the telephone helpline considered it beneficial and cathartic for the survivors as it provides an anonymous, yet guided and supportive space for sharing their abusive experiences.

> *"Telephonic counselling, our experience of 16 years, after handling more than a lakh (100,000) of calls, says that it's basically a crisis intervention situation. You intervene in the crisis, at least you allow the person to ventilate and you make the person at least to come out from that stage or the ventilation itself, I think, makes the person feel good, 70% of the time."* (Founder and Counsellor, Voluntary Organisation 6, India)

Talking to someone about CSA (referred to as "ventilation") itself is considered to be cathartic for some children. However the above professional indicated that, out of the children who use the telephone helpline, only "*20% children call back*" and "in *1 or*

2% cases, they come for face-to-face counselling". This could either mean that the children are satisfied after the initial "ventilation" or were unable to contact again due to the social-cultural barriers or fear. Their safety (or lack of it) also cannot be ensured as it is unknown whether the sexual abuse stopped or continued after the initial call was made. However, it does indicate that there are a number of 'invisible children' wanting to seek anonymous and confidential services.

5.3.2 Joint Intervention with Children and Families: First Level Crisis Intervention

Quite a few organisations undertake 'first level crisis intervention', sometimes referred to as the "first Aid". The main aim of this intervention is to facilitate support during legal proceedings and/or to rehabilitate the child survivors. Considering the structural deficiencies in India, this intervention as a first step seems critical to help survivors and their families report CSA and provide practical support to them. This may be viewed as a close equivalent of the social care support provided by the Tier 1 Universal Services in the UK, however this is not part of the statuary services as in the UK. The main thrust of this intervention is to provide the physical, emotional, moral, medical, financial and/or legal support as may be required by sexually abused children and/or their families. Besides providing direct practical support, this intervention facilitates police reporting of CSA by families in the knowledge that support is available.

> *"So basically, my whole thrust is first aid I would say. Then depending on what they go for and want, offer them legal support systems, do they need to get a new place to stay, do they need to find a police officer who will help them, do they need an organisation which will back them up."* (Founder and Counsellor, Voluntary Organisation 3, India)

It also includes assessing the needs of the families and providing support as required including providing physical and emotional support during police and legal process.

> *"We have to produce them, now and then, before CWC* (child welfare committees). *We need to accompany them to the court when the cases come up. Uh, we need to give them mental support, moral support. So mostly I keep meeting them now and then, just to ask how they are, what*

> *they are doing, how is everything, how are they feeling. So I continuously meet them, if they have any trouble, any problem, to ask them."* (Support Worker, Voluntary Organisation 4, India)

Creating physical safety for children also forms a part of the first level crisis interventions because most often the abuser is still in the family, especially where legal action has not been initiated at the time of approaching the NGO or where families are reluctant to file a police compliant.

> *"We suggested to her and helped her also to get into a hostel in the college. That helped her a lot because the parents would not have allowed her to go and stay anywhere in Delhi."* (Founder and Counsellor, Voluntary Organisation 6, India)

This first level crisis intervention also seems to have a therapeutic impact due to the physical and emotional support provided and the practice of psychoeducation on CSA, its impact, and information on services and support available being an important component of it. Professionals consider this to be reassuring for children and their families and helps in normalising their feelings and fears. In this sense, some of its components overlap with the next phase of intervention (Stabilisation and Resilience Building), for example, reassurance, psychoeducation on CSA, normalising feelings, and ensuring safety.

> *"Ideally, I generally, I don't do counselling with them, my thing is basically the first step, it's like the first stage in child abuse. So my job is to reassure the child and the parents that nothing horrifying has happened; that there is legal help available; that you can heal from it; that you know boundaries have been crossed; it's not the child's fault and that it happens to a lot of people and they can easily fight it and go beyond it, and things like that. And then talk to them about how many people are there, willing to stand by them."* (Founder and Counsellor, Voluntary Organisation 3, India)

This crisis intervention was considered to be "holistic" intervention where the focus is more on 'rehabilitation' and 'integration' of the survivors within the family and community.

> *"But it in our view and the whole project perspective, it was to rehabilitate her* (referring to a girl child survivor) *from every point of view. Within the family because of the abuse, the interpersonal relations and all that has gone, become disturbed. Then within the community, that is another angle. And then, how the system responds, gives relief to her whether it's handling by the police, by the court, by the hospital.. And putting everything together, that is the holistic thing we are looking at."* (Founder and Counsellor, Voluntary Organisation 6, India)

The above extract indicates that the "holistic rehabilitation" is viewed from the lens of social and structural factors, and the attempt is to address both for the wellbeing of the survivors through the first level crisis intervention. It may be important to note here that addressing the mental health and therapeutic needs of the child survivors does not seem to be included as a part of "holistic" rehabilitation or intervention.

5.3.3 Family Focussed Interventions

The aims of the interventions with the families are to address stigmatisation, enhance receptivity of the families and harness greater support for the child survivors when disclosers are made. As discussed above, one way of working directly with the families for the professionals is through the first level crisis intervention by providing them the required support when CSA is revealed.

The other key intervention with parents identified in India is the awareness workshops with parents (and teachers) in schools. The professionals considered that the aim of these workshops is threefold – prevention; facilitating identification and disclosures by educating parents about CSA including possible signs and/or changes in children as an impact of it; and to foster receptivity towards any possible disclosure of CSA by the child. Usually organisations that conduct PSE and/and or sexuality education workshops in schools with children, do the same with parents and teachers as well in separate groups. This practice ensures that children and their immediate support system including parents and teachers in schools are educated about CSA at the same time - yet again a way of addressing the social factors and structural deficiencies at the same time.

> *"Training parents and teachers is a different kind of training; even giving a lot of theoretical input on CSA: how it happens; what is the abuse dichotomy; what are the injunctions that the child gets; how does the child read the messages."* (Founder and Counsellor, Voluntary Organisation 1, India)

However, since these workshops with parents take place in schools, it is inferred that these inevitably exclude families of children who don't attend schools, including slum or street-based children and very young children. This seems problematic considering that the national study by the MWCD (2007) in India emphasises the vulnerability and risks of street and slum-based children to CSA.

5.3.4 Community-Focussed Interventions

Interventions with the communities including larger social and political system including schools, police, legal system, policy makers, and government are undertaken by the professionals.

> *"So, working on the social-legal aspects, working on the advocacy in the family or in the school or in the NGO, where such cases are met, and how these advocacies can bring about a social change by being aware, being responsible and being empowered to report such cases ."* (Psychiatrist, Hospital 3, India)

The first aim of these interventions, both in India and the UK, is to sensitise the concerned stakeholders in greater identification of children with CSA experiences, mitigate stigma, and harness support for the survivors and their families/safe carer(s). Professionals achieve these through awareness workshops and trainings with police, doctors and other local stakeholders in India. Most agencies in the UK were also found to be providing consultancy and training services to other multi-agency professionals such as social work, health visitors, GPs and school personnel including residential schools.

Professionals, particularly in India, emphasised that another aim of these interventions is to address the systemic and structural deficiencies. Besides consultancies, training and awareness workshops with key stakeholder, an example

of a collaborative intervention by an NGO and a local mental health institution was provided by a professional engaged in this initiative. It was referred to as a community-based 'Collaborative Child Response Unit'. It brings together different stakeholders/multi-disciplinary teams under one umbrella to address the concerns of child abuse with the main aim of making the legal and medical procedures child (and family) friendly. Initiated as a pilot project in one state of India, these units have been set up in local hospitals involving doctors, social workers, and the police who are trained on issues of child abuse. It ensures that children and their families are not traumatised and re-victimised during the legal proceedings.

> *"The child is handled only once. The idea is to have only one interview, rather than 7 or 8 interviews. So basically… talking about a one-stop centre where, except that it happens to be in a hospital. Because we don't have any effective child protection systems or child protection services anywhere where we could take the child. Till today, the police station was the place where child abuse cases would land up."* (Founder and Counsellor, Voluntary Organisation 3, India)

This initiative has been set up for children who have disclosed and where the families decide to report CSA and initiate legal proceedings. Mental health or therapeutic support does not seem to be included in these units besides the necessary emotional support required for legal proceedings. Further, it has not been evaluated yet since it is in its early stages of implementation. However, this provides an example of a multi-disciplinary service that exclusively addresses the legal and medical needs of sexually abused children and their families in one place. At the same time, it also seems to challenge the social-cultural boundaries by being located in a local hospital and providing training to local stakeholders and community members.

These interventions with children, families and communities are also considered to be significant by the professionals for getting the perpetrators penalised. Consultancy and trainings of the police and other personnel in the criminal justice system are also conducted to sensitise them with the hope of better treatment of the survivors by them and getting the perpetrators to task.

> *"But I still feel that helping the child to cope up is all right, yes, we all need to do that, it's the best. But I think the law and the science of abuse is now telling us that, yes, the perpetrators need to be taken to task, because otherwise, the acts of abuse are going to be repeated."* (Psychiatrist, Hospital 3, India)

The above findings regarding the Social Action interventions resonate with other studies that recommend interventions such as educating children about sexuality including 'good' and 'bad 'touch'; increasing awareness of parents and others including schools, physicians, and police; and fostering positive parenting styles through effective parenting programmes for addressing CSA in India (Rinchin & Maitra, 2001; Vijayalakshmi & Seshadri, 2001).

Evidence of positive outcomes of the 'Social Action' interventions in both social and structural domains was also provided by the professionals in India. It indicates the need and to some extent, effectiveness of these interventions to achieve the desired goal of 'breaking the silence' for child and adolescent survivors of CSA. Greater public awareness and increased reporting of CSA is considered as one of the significant outcomes.

> *"What is happening now, many cases* (of CSA) *are coming to light, which has happened much earlier, like 3-4 months back, 1 year, 2 years back. If something new has happened, so people are coming out and reporting... What is happening is the whole environment has become so conducive to reporting that people have shed those inhibitions, to great extent. So this has also led, to some extent, I'd say, de-stigmatisation, in a way, which is very positive."* (Founder & Counsellor, Voluntary Organisation 2, India).

Positive changes in the legislations on sexual abuse of children were attributed to these interventions by the professionals, for example, the introduction of a recent legislation, POCSO, 2012. Even though changes in the legislations and policies on mental health and therapeutic provision for sexually abused children have not been reported, mental health care provision for witness protection during legal proceedings and court trials are included in POCSO and provision for mental health

services in children's institutional/residential set-up is emphasised in the Juvenile Justice (Care and Protection of Children) Act, 2000 (JJA, 2000).

Similarly, changes have been reported in the number of professionals entering the therapeutic practice on CSA, even though overall there are concerns about the quality of training on counselling and psychotherapy in India, including CSA-trauma therapy.

> *"But, of course, it's much better now than it was ten years ago, more and more people are also getting trained and have the passion."* (Founder & Counsellor, Voluntary Organisation 1, India).

Considering the significance of community-based interventions in the Indian context, situating CSA mental health services within the community mental health framework was emphasised including training and sensitising professionals and creating multi-disciplinary and multi-tier service system.

> *"India needs multi-tiered professionals who can work in the community set-up. The work is to develop multi-tiers of the mental health professional with focus to the community mental health. India must open and develop institutions to train the largest professionals having the public health mental health outlook."* (Founder and Counsellor, Voluntary Organisation 4, India)

Within the UK, even though the ethnic minority-based organisations have emphasised the need for awareness and education on CSA for children as well as families and communities, it was recognised that not much work is being done in this direction yet.

> *"There is a lot of work to be done around raising awareness and education, which is not being done. There is a need to do educational work with young people and children from a very young age."* (Case Worker, Voluntary Organisation 4, UK)

Within the Social Action Framework, one of the key activities identified by these professionals in the UK was the support groups for educating and providing support to children and adolescents from ethnic minorities. However, disclosures of CSA did

not seem to emerge as an outcome of these sessions as shared by the professionals in India. Perhaps, because the focus of these support groups or sessions was not primarily CSA or sexuality education directly, although issues such as personal safety, cultural identity, growing-up and inter-personal relationships apparently were being discussed. Since no disclosures of CSA by children and adolescents were made in these sessions or otherwise with the exception of one case, therapeutic practice with children from ethnic minorities could not be verified. Further, sexually abused children were also not seen to be accessing services from the CSA Specialist services of CAMHS and other voluntary organisations interviewed. A gap in the availability of and access to therapeutic interventions for the sexually abused children and adolescents from the ethnic minorities in the UK has also been reported in the recent review of services for sexually abused children in the UK (Allnock et al., 2009).

5.4 Transition of 'Social Action Phase' to the Next Phases of Therapeutic Interventions

Most professionals in India were found to be engaged primarily in this phase of intervention. In some cases, child-focused interventions and/or supportive therapy ended with some inputs for prevention of revictimisation from the fourth phase identified in these findings i.e. 'Maintenance and Relapse Prevention'. However, a few professionals undertook long-term therapy with child and adolescent survivors of CSA in India, discussed in following chapters.

Overall, some professionals believed and hoped that if the interventions discussed above successfully address the cultural factors, create a conducive and supportive environment for children to disclose abuse, and foster sufficient protective factors for the child such as the supportive family and community members, Social Action by itself may prove to be therapeutic for the child. It may then prove to be a complete and holistic intervention by itself, including meeting the therapeutic needs of children.

> *"I think a lot of our effort goes into that, building that up, rather than specific services for children, to be able to train and to be able to*

> *empower services that are existing or empower parents and teachers to* ***handle that*** *first level or even be able to identify and help a child disclose sexual abuse, and handle that disclosure – if these three things can happen… may be the child doesn't need long-term therapy, well that's our wish."* (Founder and Counsellor, Voluntary Organisation 1, India)

Arguing that, *"individual healing and social action needs to go together, one cannot work without the other"*, a few professionals expressed the need for therapy for child and adolescent survivors and considered this phase of 'Social Action' as a starting point due to the nascency of interventions on CSA in India.

> *"I think we are just still trying to get towards systems in Europe and America, and we're very nascent in our whole set-up as yet. I feel we are very far behind, still."* (Founder and Counsellor, Voluntary Organisation 3, India).

5.5 Social Action Framework: Conclusions, Discussion and Summary

To conclude, it is evident from the findings that the most significant first phase of intervention on CSA, primarily in India, is the 'Social Action Framework' largely being undertaken by the NGOs to create a safe, open and conducive environment for child and adolescent survivors by addressing the cultural factors. This intervention model, even though technically not classified as a 'therapeutic approach' is considered to be cathartic as it aids identification and disclosures of child and adolescent survivors.

Echoing the need for addressing the socio-cultural interventions for prevention and protection of children, some researchers in India have argued that, "CSA has its roots in the socialisation process and does not exist in a vacuum" (Rinchin & Maitra, 2001, p. 276). Hence, interventions to address the socialisation process within which CSA perpetuates seem necessary. Borrowing from the learning from other fields, the review of literature indicates that the aspects of stigmatisation, discrimination and collective denial have been studied more extensively in the HIV field, and are considered central to the AIDS challenge globally (Duffy, 2005; Parker & Aggleton, 2003). This seems similar to the challenges of shame, silence and stigma that have

been found to be associated with the field of CSA. In order to address the socio-cultural barriers and issues of stigmatisation, a shift of trend is being considered in the HIV sector from highly individualistic modes of stigma alleviation towards greater social action through community organising and community building for wider social change (Parker & Aggleton, 2003). Even though these researchers acknowledged that the effectiveness of such interventions in stigma reduction still needs to be studied, it is indicative of a trend of adopting a social and community-based intervention over the individualised modes to address stigmatisation that is socially triggered and sustained.

Table 5.1: Summary - Social Action Framework

Intervention	Social Action Framework
Key Goals	• To identify and release the silenced child in a culture of silence and suppression in India. • To increase acceptance of CSA survivors by raising awareness and mitigating stigma.
Key Strategies/ Interventions	• Child and adolescent focussed interventions, such as PSE or sexuality education and telephone counselling. • Joint child and family interventions, such as the first level crisis intervention. • Family-focussed interventions to harness greater support by addressing stigmatisation, such as psychoeducation and education workshops with parents in schools. • Community-focussed interventions including the larger social system i.e. schools, policy makers, and government, such as advocacy initiatives with the policy makers.

With regards to the limitations, it can be argued that the practice of 'Social Action' interventions, although beneficial, seems to be quite restrictive. These are being undertaken by a handful of NGOs based in few bigger states of India and have a limited outreach. Further, it is drawn from the findings that none of the organisations have evaluated the effectiveness of these interventions undertaken by them, except for pre- and post-test PSE assessment being done by one NGO. PSE and sexuality education in schools have come across as key direct interventions being practiced with children and adolescents, that too seems to be limited primarily to few school-

going children. Hence, it can be argued that the professionals in India shared a number of challenges and barriers to CSA work and disclosure in India, however the interventions reported do not seem to match the vast challenges expressed, number of children suffering from CSA, as well as the diversity and size of the country. However, these limitations can be attributed to the nascency of the stage of interventions on CSA by the NGOs in India and lack of responsibility and ownership of the government to set up statuary provisions including mental health and therapeutic services for the survivors of CSA.

Lastly, from the findings it is evident that the therapeutic needs of sexually abused children in India are not being met currently even after the disclosures are made. However, professionals largely acknowledge the need for therapy for sexually abused children and adolescents. The minimal existing literature focussing on sexually abused individual reinforces the need for counselling and therapy from the clients' perspective. A study with adult female survivors of abuse in India revealed that the survivors recommended facilitating counselling cells (Vijayalakshmi & Seshadri, 2001). Kakar (2000) while on one hand highlighted the dividual and relational qualities of individual and social system in India, reaffirmed from his mental health practice as a psychoanalyst in India that "the patients are more individual in their unconscious than they realise and often seek western style psychotherapy partly in order to be comfortable with their individual needs and striving (p. 275)". The views of the professionals in the study resonate with the need for therapy for survivors of CSA. However, their seem to be a larger consensus towards positioning the therapeutic services within the community mental health set up rather than the 'western style psychotherapy' due to the professionals' concerns regarding the lack of cultural adaptation of the latter. Even though the practice of community mental health in India seems appropriate at the outset given the socio-cultural factors, some researchers are quite critical about its current practice in India due to the lack of government's interest in setting it up including the lack of infrastructure and budget allocated for the same (Jadav & Jain, 2012). This again points towards the structural challenges and confirms the findings of the study about the overall lack of statuary services and government's lack of initiative towards

mental health practice in India. The study highlights a need for statutory provisions and services, multidisciplinary teams and better multi-agency collaboration in India to ensure CSA-specific therapeutic interventions for child and adolescent survivors and their families.

Cultural barriers were also identified in the ethnic minority communities in the UK including gaps in the culturally-sensitive service provision for the survivors. The need for better understanding of cultural issues and provision of culturally-specific CSA services including therapeutic services for the ethnic minorities in the UK is another important finding of this study. There is a big vacuum in research in these areas.

Chapter Six

Stabilisation and Resilience Building Framework: Grounding the Apprehensive Child

The Prerequisite for Challenging CSA-Trauma Therapy

"The work with integrating the traumatic experience comes later in the therapeutic process. That there are other things to be done through in between."

(Therapist, Voluntary Organisation 2, UK)

6.1 Introduction

The findings revealed that the therapy with child and adolescent survivors of CSA does not begin with addressing the CSA trauma immediately. In the initial phase of the therapy, both in India and the UK, therapeutic interventions are undertaken to stabilise and build resilience in child and adolescent survivors. This helps in building the foundation and preparing children and adolescents for discussing and dealing with the trauma of CSA, leading to the next phase of CSA-trauma resolution and integration, particularly in the UK.

> *"David Trickey, who works with complex trauma, he's got this quite helpful model on how you have to do a lot of work, really, in this initial phase before you ever get to the trauma focused work up there. You'll be doing a lot of stabilisation, family work, helping the person feel safe, before you get to this more technical stuff. And it is the point about the pyramid, you just have to do so much down there, to engage and support them to be in a state that they can do this quite challenging work* (referring to CSA trauma work)." (Psychiatrist, CSA Specialist Service 3, UK)

All professionals interviewed in the UK and six of them in India engaged in direct therapeutic practice with children, beginning with the 'Stabilisation and Resilience Building' phase. Different terminology was used by professionals referring to this phase of therapy, such as "stabilisation", "engagement", "approximate and immediate intervention" and "resource development". However, the overall aim and

specific therapeutic interventions practiced seemed similar. These professionals undertake stabilisation work with both the children and families concurrently. The professionals' frame of reference and the therapeutic interventions undertaken in this phase are presented in this chapter. The challenges, complexities and limitations related to this phase of interventions are also discussed, substantiated by the review of associated literature.

> *"What we call as the immediate and the proximate intervention. Immediate intervention is if the abuse happened yesterday, intervention* ***must happen*** *today. An intervention would be providing a safety net support, security for the child, a little change of environment, with the effort to come back to the normalcy of life, at a personal level, at a peer level, at a social level, entertainment level."* (Psychiatrist 3, India)

In the UK, this is the first phase in CSA therapy and in most cases, flows into the next phase of CSA-trauma specific therapy. However, this was found to be the only phase of CSA-therapy in most cases in India given numerous cultural challenges, which makes this phase a critical intervention by itself.

6.2 Professionals' Frame of Reference: External and Internal Safety and Stability

The Interventions in this phase were found to be driven mainly by two concerns of the professionals: i. External safety and stability, referring to the child's environmental, physical and social factors; and ii Internal safety and stability, referring to the child's inner self and addressing emotional and psychological factors.

6.2.1 External Safety and Stability: Environmental, Physical and Social Factors

External safety and stability includes professional's concerns for child and adolescent survivors of CSA around their physical and social safety in their immediate environment. Physical safety includes concerns about any ongoing abuse and harm being caused to the child and/or safe and secure physical environment of

the child. Social safety concerns are related to safe, stable, secure support system around the child.

> *"Ideally the child needs to be in a safe situation, well, I say ideally, I think, actually,* ***crucially*** *– the child needs to be in a safe situation"* (Psychiatrist, CSA Specialist Service 4, UK)

The foremost concern of the professionals, both in India and the UK, was around the safety of the child from any ongoing abuse and harm when referred for therapy. Although it did not emerge as a prominent concern for professionals in the UK from a therapeutic perspective as the sexual abuse is disclosed and investigated by the time of referral for therapy. However, in some instances, another abusive experience was revealed by the child during therapy.

> *"Sadly, sometimes you find that a child that you're working with is still being abused. And that comes up, either the child tells you or you realise from the way that they're behaving in a therapy session, that something is still not right."* (Consultant Psychiatrist, CSA Specialist Service 4, UK)

In India, a high likelihood of the same was shared by the professionals, especially when the abuse was disclosed first time directly to the therapists through PSE or sexuality education sessions, telephone helpline or situations where CSA disclosure emerged during therapy for other behavioural, emotional or academic concerns that the child was referred for initially. These concerns were aggravated by the possibility of the perpetrator being in proximity of the child or the same home environment, which was most often the case in intrafamilial abuse. This comprises the physical and emotional safety of the child. This also did not seem to bother the professionals in the UK. Following disclosure of abuse, most often the abuser was already removed from the family by the time child entered the therapeutic set up. However, within the UK, the key physical safety concern centred around safe and stable accommodation and physical living conditions of the child.

> "*You can't work therapeutically with a child if they're not ready for it. But essentially, I suppose it means that… em it's the idea, I suppose, of do no harm as well, isn't it! That if the child is all over the place, because they don't know where they're sleeping next week, for example, they may*

be… in a refuge with their parents or they may be uh being looked after… in a temporary accommodation." (Therapist, Voluntary Organisation 2, UK)

In the same context of physical environment and situation of the child, professionals in the UK also talked about the need to be aware and mindful of any court investigations and proceedings going on at the time child and adolescent survivors are referred for therapy.

"Things like whether there is ongoing investigation, whether there is a court process." (Clinical Psychologist, CSA Specialist Service 1, UK)

Linked to the above two aspects, the third concern of professionals in India and UK was about the social support system of the child. Professionals considered it essential to ensure if the safe parent(s)/carers were stable enough to be able to support the child through the therapeutic process. This included any possible substance or alcohol misuse and/or any other mental health issues of parents.

"*Is there enough support around to enable them to engage in therapy and to progress through therapy? So is the parent or carer able to bring them, for a start. Because if they're not, if it's going to be sporadic then that's not going to be helpful, it's going to be very difficult for the child."* (Clinical Psychologist, CSA Specialist Service 1, UK)

The support system, essentially a stable and supportive family, was considered important by professionals in India and UK to ensure child's stability within and outside the therapeutic set up.

6.2.2 Internal Safety and Stability: Psychological and Emotional Factors

Internal safety refers to strengthening the child's inner self by addressing the psychological and emotional factors. Most professionals considered it important to discuss the traumatic sexual abuse experience(s) in order to help the child with 'trauma resolution and integration', however they maintained that it takes time for children and their families to start discussing CSA trauma details. The therapists in India and the UK maintained that it is extremely difficult and challenging for children and adolescents (and their families) to start talking about and dealing with

CSA trauma in therapy. This was due to the nature of complex trauma experienced by children and adolescents and its impact on them and the factors of shame, guilt, fear, secrecy and other culturally suppressive factors under which CSA perpetuates. Children and/or their families were considered to be emotionally quite vulnerable and anxious initially when they come for therapy. Hence, the interventions in this first phase helps the professionals to overcome these challenge that pose to be barriers for engaging children in therapy.

> *"I think it's very hard to engage people because I think the work is so hard for patients… People are very ambivalent, actually, about talking about the abuse, so having to come to something, where it gets opened up is often quite difficult. So it's very mixed sometimes."* (Psychiatrist, CSA Specialist Service 3, UK)

As in any therapeutic setting, their initial inhibitions have been attributed also to the lack of familiarity and sufficient association with the therapist. This includes fears and uncertainty related to not knowing the therapist and the therapeutic setting enough when they come for therapy.

> "*But some* (referring to children) *are not able to talk about how it started and so on, what happened, how long it happened, so the details of abuse may actually take quite a while… I guess sometimes you don't know them, really*." (Psychiatrist, CSA Specialist Service 4, UK)

Professionals believed that children are quite anxious when they come for therapy initially about the therapeutic process including the therapeutic setting/place (an unfamiliar territory), therapist (who is a stranger), and the therapeutic intervention (not knowing what is expected or what will happen). These concerns apparently are aggravated in CSA therapy given their lack of trust in adults. They feel emotionally unsafe and threatened, which alleviates their anxiety with the therapist initially.

> *"As soon as you pick a child from the waiting room they already are seeing, you know, 'do I feel safe and what do you expect from me!'... They have only known things not to have kept safe, they were not kept safe and that's why they are here, so safety is quite essential cos potentially it is quite threatening to be with a stranger in a space."* (Art Therapist, CSA Specialist Service 1, UK)

The fear of force and coercion experienced by many children in process of CSA may be also extended to the therapeutic space, given that they are often referred for therapy by significant adults rather than making this choice voluntarily. Hence, they sometimes fear being forced to attend therapy and talk about their CSA experiences, which was considered to be another challenge for engaging children in therapy.

> *"They're often very anxious about coming to a place like this really and very worried about whether they're going to be forced. I think the treatment side is very variable and there are real problems in successfully engaging them for treatment."* (Psychiatrist, CSA Specialist Service 3, UK)

A number of children presented with severe difficulties or symptoms including self-harm when referred for therapy. Stabilising some of these severe symptoms particularly self-harm and minimising anxiety of children as well as their families associated with such presenting difficulties before they move on to processing traumatic memories and experiences is considered critical.

> *"Stabilisation was the first phase. So unless they* (children) *know how… soothe themselves, able to take care of their… emotions, okay, if I go straight back to traumatic memories it will be extremely overwhelming. So many of, most of the girls are dissociative… So many of them would use self-harm behaviours outside.. before coming in here. So suicidal ideations. So and in the first and I never had intensive history taking and even if I had attempted, girls wouldn't feel safe in the beginning to give me their entire history."* (Independent Trauma Therapist, India)

Developing internal resources or building resilience of children and families was considered critical by professionals in India and the UK to pave the way for ensuing hard and challenging trauma-specific work, even to get children to a stage where they are able to open up and comfortably share traumatic experiences and history with the therapists.

> *"There is one particular girl. In the beginning I used to work only on resource development, just make her feel umm because there was no point in doing trauma work. So I wanted her to be stable enough, if she feels extremely overwhelmed what to do about it!! So more of resource*

work was focused on umm and after resource work more history would come in." (Trauma Therapist 1, India)

They were also guided by the specific impact of CSA on certain areas of child's functioning and world view, for example, trust; difficulties with disclosure; self-blame; and low sense of self. According to the professionals, some of these factors made it hard for children to talk about CSA and made them anxious when they came for therapy, proving to be barriers to engagement in trauma-specific therapy. Hence, settling some of these issues of children in this initial phase stabilises them, facilitates engagement in therapy and with the therapists, and builds resilience or develops adequate resources in them for the next phase of trauma therapy.

"*And a lot of the unconscious em effect of being severely traumatised and abused, in the way that we've been talking about, is that they don't trust and they won't allow themselves to get close. And in order to achieve that with a child, or indeed an adult, I think it takes a long time for the trust to be built up before the difficult inner material can begin to come out and be dealt with*." (Clinical Psychologist 2, CSA specialist Service 1, UK)

6.3 Stabilisation and Resilience Building Framework: Key Interventions

Two areas of interventions in this phase of therapy were identified for grounding the child: i. Interventions to secure external safety and stability, primarily practiced by professionals in India; and ii. Interventions for facilitating internal safety and stability, practiced in both India and the UK. Both these interventions started with the assessment of the needs and circumstances of child and adolescent survivors of CSA.

Figure 6.1 presents the summary of the Stabilisation and Resilience Building Phase.

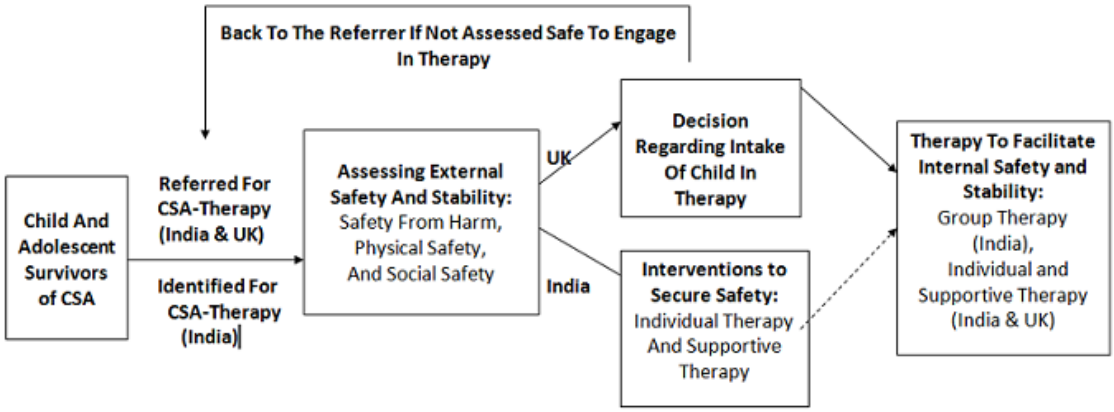

Figure 6.1: Practice of Stabilisation and Resilience Building Phase

6.3.1 Interventions: Securing External Safety and Stability

Most professionals in the UK and a few in India spend the initial 3-5 sessions in assessment and case formulations. The interventions begin with assessment of children's circumstances to assess safety including protective and inhibiting factors in their physical and social environment. In the UK, most of this information regarding safety and stability of children in their immediate familial and social environment was gathered through referral forms/letters and interactions with safe parent(s)/carers, social workers and/or other referrers. For professionals in India, this assessment was primarily based on interactions with the child and/or where possible, by involving the accessible parent, usually the mother.

> *"The rationale for meeting the social worker is either to get more information, we haven't understood all the information we need, and partly because we're not quite sure what the safety plan is and what the plan from their side of things would be. So we would, quite **often** meet with the social worker first*." (Psychiatrist, CSA Specialist Service 4, UK)

An exception to this assessment was found in India, where the therapist straight moved on to stabilisation therapy without undertaking a formal assessment. Lack of

time and resources was attributed as a reason for the same, since every session had financial implications for families in the hospital setting in India.

There was a difference in practice of the professionals in India and the UK based on the above assessment of safety in the child's environment. These interventions are discussed below.

6.3.1.1 Multi-Agency Collaboration

In the UK, the above assessment facilitated the therapeutic decision about the intake of child in therapy.

> *"At the end of assessment, decision will be made if the child is safe enough, is able to engage in therapy and have the support system to engage in the therapy and when that's put in place, the child would come*." (Art Therapist, CSA Specialist Service 1, UK)

If the family and overall environment was not considered to be safe and stable, the child was referred back to the referrer such as the social workers to ensure safety, before he/she could be engaged in therapy. The same procedure was followed if a suspicion or disclosure of another ongoing abuse comes up at any point in therapy. The professionals interviewed in the UK appreciated this multi-agency collaboration for ensuring child's safety.

> *"Probably the expectation would be that Social Care need to make some safety plan before we could start any meaningful treatment work that wasn't counterproductive."*(Social Worker, CSA Specialist Service 3, UK)

> *"And then you speak to the social workers and they investigate and then, sadly, you often find out there is other abuse going on. So, you need to have this very important holding system, not just in the therapy."* (Consultant Psychiatrist, CSA Specialist Service 4, UK)

The professionals in the UK appreciated multi-agency collaboration or a "holding system" in terms of social care and Universal services (Tier 1) to fall back on. They considered their role of providing CSA-therapy as a component of overall

interventions necessary for child protection, confirming the need for multi-disciplinary and multi-agency interventions.

> *"So you're providing a particular kind of help, but you know, you may often need people, like social workers, to help insure the child's overall safety. So you're providing one component of the overall plan to help."* (Psychiatrist, CSA Specialist Service 3, UK)

Hence, these professionals in the UK do not proceed with therapy if the child is not assessed to be in a safe, stable environment. Based on their understanding about the challenging and emotionally demanding nature of CSA-trauma therapy, these professionals conceded that the child needs to be in a safe and stable environment to be receptive to therapy with appropriate support system.

> *"Because that's the other part underpinning this, that really, the child has to be in a safe environment to actually enter into the therapeutic process and the therapeutic work."* (Therapist, Voluntary Organisation 2, UK)

This decision about the intake of a child in therapy, on one hand, seemed to be driven by concerns about "readiness" or "receptivity" of the child based on stability in his/her physical environment. However, this may also reflect 'concern regarding the service'. Due to the current resource-driven circumstances in the UK such as limited financial and human resources, the agencies/organisations seem to be compelled to invest in cases that would prove to be productive reflecting positive outcomes for the services.

> *"So all the time we are thinking we want to engage these young people, we know they are vulnerable, that they are sometimes in a tricky situation, but at the same time we are too mindful that we are a service, there are other pressures on us too."* (Clinical Psychologist, CSA Specialist Service 2, UK)

Overall, shared responsibilities among different professionals and services through multi-agency collaborative interventions seem beneficial for ensuring overall child protection including safety from further harm and safe environment.

6.3.1.2 Child-Focussed and Supportive Interventions

Due to the lack of the statuary system and services in India, the interventions to secure safety in child's immediate environment become the first step in therapy for the practitioners interviewed. These include interventions directly with the child as well as supportive interventions by engaging the safe parent/carer and/or significant trusted adult from the child's immediate environment.

> "*Wherever there would be a doubt about such an abuse happening, I think the first and foremost initiative has to be to provide a complete, safe, secure, supportive environment, from the point of discovery".* (Psychiatrist 3, Hospital, India)

6.3.1.2.1 Child-Focussed Interventions: Psychoeducation and Role Plays

The professionals worked towards facilitating disclosure to the parents/trusted adults when the CSA was revealed for the first time by the child in therapy itself. They helped the child identify a trusted adult as a first point of contact to whom the disclosure could be made, which turned out to be the mother usually. Role-plays were used as a medium to help the child disclose sexual abuse to the identified significant trusted adult preceded by psychoeducation to the child about CSA including information on the grooming process and need for parent(s)/carers to be informed in order to stop ongoing abuse.

> *"So we always try to understand, 'who is your trusted adult?' The child says, 'Mother is my trusted adult.' 'What will happen if you tell it to your mom? How can she help you in the process?' So then the child feels that yes, the mother can help me. We do it through the help of a role play. So I become the mother, you are the child, and how would I react and how would the child handle it."* (Trauma Therapist, Voluntary Organisation 7, India)

A number of case-examples of children (ages 12+) of disclosures through this process were revealed. These professionals in India argued that through the process of psychoeducation and role-plays, most children were able to reveal their abuse to

the identified trusted adult with or without the presence of the therapist. With some children, especially in cases received through the PSE sessions, therapy usually stopped after disclosures were facilitated. Facilitating disclosure to an identified family member was by itself considered to be therapeutic as living in silence or suppressing these traumatic memories aggravated the trauma in children. Further, this process of facilitating disclosure was considered to be cathartic and empowering for the child. It not only helped stop the abuse by engaging the primary care giver/significant trusted adult, but also enhanced their assertiveness and communication skills. However, other professionals considered its scope limited for child's recovery or healing from trauma, reiterating the need for trauma-therapy after disclosures of CSA are made.

> *"Disclosure can be an important part of that, but I don't think that is the part in itself that would be the healing one."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

In cases of older children with past or historic sexual abuse, if they did not want to discuss it with the family members, other aspects of psychological and emotional safety and stability were ensured. However, in case of a younger child and/or ongoing abuse, the therapist contacted the parents directly to report harm and ensure child's safety if the child did not agree to disclosing CSA to the parent(s). Reporting harm to parents seemed more at discretion of the therapist at the time interviews were conducted in India. However, with the new legislation, POCSO 2012, reporting of harm to parents and concerned authorities has been made mandatory, which is similar to the procedure followed by professionals in the UK. Although, most of the professionals interviewed in India seemed critical and sceptical of it at this juncture and speculated more of negative consequences of this practice for child and adolescent survivors. They feared that it may constraint their therapeutic practice and access of services by children and their families further, pushing them deeper in 'invisible and silenced' domain due to the same cultural factors discussed earlier. Lack of clarity in the legislations about how the cases of CSA would be handled once reported by the professionals further added to their fears.

> *"Most of the time, paediatricians, private practitioners have told me, 'we know abuse is occurring; if we try to tell somebody, the parents just pick up the kid and leave; and they say, don't go to that doctor, they're very bad because they're trying to create trouble.' So they end up stopping the child for support, you know! So, mandatory reporting is good but it's of no use, whatsoever, if you don't have systems for reporting which are sensitive and confidential."* (NGO Practitioner 3, India)

Some professionals in the UK confirmed the above fears as they shared challenges faced by them sometimes due to this legal obligation of reporting harm and its implications on the therapeutic interventions for child and adolescent survivors of CSA. The role and judgment of the therapists in this regard was considered to be critical, especially in cases involving older children or adolescents.

> *"Well, there are some situations when it's just awful. When we tell somebody, sometimes, then, in the past it would be that sometimes therapy would be stopped, which was awful, the child felt really bad. Sometimes, the child just needs you to hold it, and especially with teenagers it isn't – sometimes they need you to hold it because they don't want the whole family destroyed. So, certainly, therapeutically, I believe that there are some situations, especially with teenagers, where I wish we could hold it. I think we panic too quickly."* (Therapist, Voluntary Organisation 3, UK)

How would this practice of mandatory reporting pan out with time in India to ensure child protection and safety needs to be seen and is perhaps a potential area for further research. However, it raises critical concerns from a therapeutic perspective. One, it is worth speculating whether it is beneficial to work through the larger system by reporting harm or mandatory reporting, or to work directly with children (and their families) therapeutically to facilitate disclosures and reporting of CSA by educating and empowering them? From a therapeutic intervention perspective, the former perhaps takes away the responsibility of the professionals and places a larger responsibility on the nation as a whole to ensure a multi-disciplinary "holding system" in place for ensuring safety of children. The latter i.e. working therapeutically with the child and the family places greater responsibility on the professionals to provide trauma therapy as well as working through the barriers including socio-cultural factors to promote safety from ongoing abuse. But, according to the views of some professionals interviewed in India, it ensures better

engagement of children (and perhaps families) in therapy, especially in India given the additional rigid socio-cultural barriers and associated stigmatisation with reporting of CSA.

Second, it can be inferred that although such systems of reporting harm are put in place to ensure safety of children from ongoing abuse or harm, it always may not succeed in meeting this objective. Not only it may pose to be another barrier for timely disclosures of CSA, it would deter children and their families from even receiving therapeutic help, which could possibly build their resilience and empower them to disclose CSA. Appropriate measures are perhaps needed to ensure that such procedures are complementary, and not counterproductive, to meeting the overall child protection goals and access to services including timely therapeutic interventions and support for CSA.

6.3.1.2.2 Supportive Interventions: Engaging safe parent(s)/carer or other identified trusted adult

Supportive therapy involves engaging safe parent(s)/identified trusted adult for securing a safety plan for the child in India. This included facilitating disclosure of CSA to safe parent(s) through empowering the child to do so, or by directly reporting harm to them. The therapists also intervened to draw a safety plan for the child in collaboration with the parents/carer including ensuring a safe space for the child away from the perpetrator. Therapy was also extended to the identified significant and trusted person in some cases as part of the supportive therapy. It helped in bridging the gap between the parent/carer and the child that existed due to the socio-cultural factors in India.

> *"We also at that point in time do a psychosocial kind of assessment also. We see that the… child's safety is ensured in the current environment. And we make sure to discuss with the caregiver, whether the child should stay at that particular place. So we discuss with the caregiver to take measures to avoid this kind of situations where the child, where the abuse can happen again."* (Psychiatrist 2, India)

As can be imagined, this was found to be riddled with a number of complex issues given the cultural context in India. One, usually it was the mother who brought the child for therapy or who was identified as a trusted family member. Given the patriarchal norms in India, usually the mother lacked control or authority within the family. Sometimes, even if the mother wanted to take action to protect the child, professionals recognised her inability to do so, especially when the abuser was the father or another older, authoritative member of the family such as the grandfather. In such situations and/or when legal proceedings against the abuser were not initiated, which was often found to be the case, professionals worked towards removing the child from the family by sending him/her to hostel/residential school. However, this was not an easy proposition for them in all cases.

Hence, these cultural factors restricted the options for securing a safety plan for the child and proved to be challenging for the professionals. It is also inferred from these findings that with or without disclosure, the circumstances of most children did not seem to change and perhaps the child continued to be in an unsafe environment, unless the parent(s)/main carer agreed to take a firm stand and action against the perpetrator. It, yet again, reiterates the need and rationale for Social Action interventions in India.

The supportive therapy intervention in India in some cases led on to 'first level crisis intervention/counselling' by some NGOs to ensure legal, medical and emotional support to facilitate police reporting and court cases if the family decided to report abuse and take legal action. On the other hand, the intervention stopped in most of the cases after this initial step of facilitating disclosure and securing physical safety.

To conclude, there was a consensus among the professionals interviewed in India and the UK that the first key step in therapy is to ensure physical safety in the immediate environment of the child. However, differing interventions and associated concerns emerged. One, the findings revealed that ensuring safe and secure physical and social environment of children is part of the therapeutic practice for the professional in India. On the other hand, the therapists or CSA-Specialist agencies in

the UK, both in statuary and voluntary sector, engaged in therapy to address emotional and psychological needs of child and adolescent survivors of CSA due to the existence of other statuary and multi-agency services to take care of aspects related to physical and social stability. This reiterates the need for the therapeutic interventions to be positioned within a larger service system and the significance of culturally sensitive multi-agency interventions/service system to ensure comprehensive child care and protection services with therapy being one component of it. The therapists in the UK appreciated this "holding system" that they could fall back on when required. This leaves the therapists with dedicated time and effort for therapeutic interventions to help the child cope better with CSA-trauma rather than dealing with the system outside the therapeutic setting to ensure safety of the child.
Second, this also suggests that while this assessment and assurance of safety may begin during the Stabilisation phase, similar issues and concerns can emerge later in therapy as well, such as possibility of an ongoing abuse. The child may need further stabilisation even if the child reached the next phase in therapy of trauma resolution. CSA trauma therapists need to stay mindful of this considering the responses of the professionals above as well as the literature on revictimisation of children with CSA experiences. This also suggests the non-linear nature of the different phases of therapeutic intervention for CSA-trauma, where there may be back and forth movement from one phase to the other.

Lastly, it is also speculated from the above discussion that trauma-specific therapy needs of a number of children are being compromised both in India and the UK. In the UK, children did not receive therapy if not perceived to be "safe and ready to engage in therapy" by the professionals or in situations where abuse was not "disclosed and investigated". In addition, the findings revealed that a number of agencies in the UK did not accept self-referrals. This implies that a number of children who may want to seek therapeutic help for CSA cannot do so in a confidential manner without engaging families/carers and/or the larger service system such as the social work, GP, school or residential care. On the other hand, in India, the interventions of most professionals who provided therapeutic services (which are far and few in any case) were diverted towards crisis or risk management

(including risk from ongoing abuse or harm), ensuring safe familial and social environment, and in some case also about investigating the authenticity of CSA experiences of children. As a result, the CSA trauma therapy needs of children seem to remain unfulfilled.

6.3.2 Interventions: Enabling Internal Safety and Stability

Children who were accepted for therapy in the UK and those who moved to the next level after their environmental safety was ensured in India were engaged in CSA-trauma therapy by the professionals in both the countries. Before delving into the details of the CSA-trauma, professionals undertook interventions for facilitating emotional stability and building resilience in children. Two core interventions were identified in this phase of therapy: i. Child-focussed interventions through one-on-one or group therapy; and ii. Supportive therapy, by engaging safe parent/carers.

6.3.2.1. Child-Focussed Interventions through One-on-One or Group Therapy

One-on-one therapy was found to be the primary therapeutic modality practiced by all respondents in India and the UK for stabilisation and resilience building. Group therapy was also undertaken, particularly by two professionals in their work with children in residential home setting in India. Group therapy was seen as a time and cost-effective medium to work on similar issues with large numbers of children. However, for the ensuing trauma-specific work after stabilisation, individual therapy was preferred.

> *"Secondly, we go to the institutions. Over there, also, why we started with group therapy was because we realised there is so much of work that we have to do with them. If we do it at an individual level and at a given point in time, we have 10 to 15 girls for therapy, it becomes very difficult to work with them on an individual level. So you take these common issues and you start working with them at a group level."*(Trauma Therapist, Voluntary Organisation 7, India)

Although all professionals in the UK also considered group therapy beneficial in conjunction with individual therapy, resource constraints and administrative

challenges in advertising and organising age and gender-specific groups apparently restricted its practice.

> *"We haven't run that for a while, we had a much bigger team at one point. It's changed…. We've got quite a small team, we meet just one day, one morning a week. And it's quite a lot of work to organise groups."* (Psychiatrist, CSA Specialist Service 4, UK)

Based on the psychological impact of CSA observed on children, professionals seemed to focus on three key domains during this 'Stabilisation and Resilience Building Phase', irrespective of the country and therapeutic modality practiced i.e. group or one-on-one therapy. These include: i. *Building a therapeutic relationship or alliance; ii. Normalising feelings and restoring normalcy in life; and iii. Assessing and addressing self-harm and presenting difficulties*. With regards to the therapeutic interventions practiced for addressing these domains, a combination of ***therapeutic factors*** *and* ***therapeutic approaches*** were found to be critical to achieve the desired or expected outcomes. In terms of specific therapeutic approaches practiced, a number of them have been noted, however most prominently and uniformly being practiced by all professionals during this phase, irrespective of the country or setting, are the creative therapies or outlets and psychoeducation. These aspects are discussed in detail below.

6.3.2.1.1 Therapeutic Factors for Establishing a Therapeutic Relationship

The therapeutic factors identified based on the responses of the professionals included: i. *therapeutic principles and administrative procedures* that are perceived as empowering by children rather than imposing; and ii. *Therapists' factors* such as personality, skills and ability to establish a "human connection" and a therapeutic relationship. Although these therapeutic factors seemed relevant throughout the therapy, establishing these clearly in the initial phase when therapy began seemed to be highly significant initially for establishing a therapeutic relationship.

Like in any therapy setting, therapeutic intervention for CSA begins with building a therapeutic alliance. However, its significance is enhanced when working

therapeutically with sexually abused children and adolescents. Professionals in India and the UK used different terminology to establish its relevance and practice, which to some extent, reflected the training, orientation and overall CSA trauma-therapy approach adopted by them.

Some professionals described this process of "building a therapeutic relationship" with an emphasis on transference, countertransference, containment (both for the child and therapist), and continuity. Others referred to it as "building a bond" to "facilitate engagement" of children and families/safe parent in therapy. Lastly, most professionals in India, drawing from generic counselling and psychotherapy principles, made references to "rapport formation" for establishing a "bond" between the therapist and child and "breaking the ice". Although different theoretical influences were found for establishing a therapeutic relationship, for example, psychodynamic approach, gestalt, child-centred orientation and/or generic counselling and psychotherapy principles, the rationale and significance of building a therapeutic alliance in CSA-therapy and specific therapeutic factors and approaches practiced for the same were largely found to be similar. This is consistent with the literature, which confirms the ''robust relationship" between therapeutic alliance and its outcome (Roth and Fonagy, 1996, p. 352; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004) irrespective of the therapeutic intervention practiced such as cognitive therapy (Waddington, 2002) or psychodynamic therapy (Horvarth and Luborsky, 1993).

Irrespective of setting and country, it was inferred from the responses of the professionals that the therapeutic factors, at a primary level, were more significant for facilitating engagement of children and a sense of security in therapy than the practice of any specific therapeutic approach.

Therapeutic Principles and Procedures for Establishing a Therapeutic Alliance: The adherence to the therapeutic principles was reflected in the therapeutic procedures followed by the therapists or their respective organisation/agencies. While some of these therapeutic factors are integral part of universal

psychotherapeutic practice, these were considered critical with child and adolescent survivors of CSA due to the nature and impact of trauma including issues of lack of trust in adults, fears and emotional vulnerability due to guilt and self-blame, and low sense of self. Given the sense of powerlessness and helplessness inherent in CSA, the therapists emphasised therapeutic principles and procedures that made children feel more in control of the therapeutic process.

First and foremost, the principle of *transparency and openness* was emphasised from the beginning of the therapy. According to the professionals in India and the UK, lack of familiarity with the therapist and therapeutic setting/place added to the discomfort and mistrust of the child. Being open about the procedures adopted by the agency facilitated initial comfort and trust of children in the therapist and the therapeutic setting. For example, introducing the child (and accompanying parent/carer) to the therapist, the therapeutic physical place (building, clinic), explaining the process and giving as much information as required helps alleviate the initial anxiety of the child and build trust.

> *"When the child is visiting, they can go around, they can ask questions about the building, they know where they're coming to, they know, they have sight of the rooms, the people in the building. We found... things that are important, like who greets them, the admin person, all of that, so they know their name… and they get familiar with the building. So all of those very basic things and we think that they all contribute and start to build that kind of therapeutic relationship. So then you're into... you're starting with those building blocks um... but you're laying the foundations of the trust, the confidentiality." (*Therapist, *Voluntary Organisation 2, UK)*

The next important aspect noted as the principle of *confidentiality* that is closely linked with building a trusting therapeutic relationship. Ensuring confidentiality in the therapeutic process including transparency about the exceptions or limits to confidentiality (with respect to the clause of reporting harm) was considered critical in any therapeutic setting, with more careful and heightened emphasis in CSA-therapy. The assurance from the therapist about confidentiality helped children open up about the details of the CSA-trauma.

> *"You just start empathising, you give them an assurance that, 'look, this is confidential, and look, this is not going to be revealed and it's only between you and me, or the organization - you know, concerned people, counsellors. And we're there to help you'. Then they open up."* (Psychiatrist 1, India)

Respecting confidentiality also reflected in the *procedure* of seeking and sharing confidential information about the child with others including child's family/parent/carer, particularly in case of an older child. It was emphasised that this, when needed, should be done with child's participation, permission and agreement. Some professionals emphasised that the adherence to such procedures not only enhanced trust of the children, but also made them feel more in control of the process rather than feeling powerless and/or dependent on the therapists leading to resilience building or resource development.

Reassurance and belief in child's disclosure of CSA without judgment and/or criticism was considered extremely critical, particularly by the professionals in India, given the lack of agency of children in general and disbelief in their disclosure by significant others/families. It seems to be a reciprocal process. By conveying belief and trust in the child, the therapists gain the same back from the child, leading to formation of a trusting therapeutic relationship.

> *"Our role is very important because we need to convey that to the child saying that we believe in whatever the child says and really it's hard to believe that, it's the child's fault in what has happened"* (Psychiatrist 2, India)

However, a contradiction was noted in the practice of above principle held by some professionals in India and actual procedures followed by them. The legal procedures or the dual role of these professionals i.e. as a therapist as well as witnesses in the court cases to provide verification of the CSA claims of the child/parent, to an extent, seemed to undermine the principle of trust and belief in the child. The need to investigate the authenticity of the claims of the child for legal purposes was highlighted with examples of the same provided, which seemed contradictory to the genuine sense of belief and trust in the child. The therapists in the UK did not seem to face such pressures as there other services were responsible for investigating

allegations of CSA before CSA referrals were received. It, yet again, reinforces the need for a multi-tier, multi-agency service system where roles of different professionals do not overlap but complement each other's service.

Ensuring the principal and procedures to *ensure voluntary participation* in therapy for enhancing child's control and ownership in the process was considered important in CSA-therapy. Given the sense of powerlessness and helplessness experienced in CSA and the fact that children were referred for therapy by other adults (and not self-referral), it was considered critical to ensure that children did not experience the therapeutic process as an imposition. Within the same context, some professionals considered it critical for the child to be aware of the reason for referral to the therapist i.e. CSA therapy. In terms of therapeutic administrative procedures, these professionals ensured this through discussions with the referrers, safe parent/carer and/or directly through children (particularly older children) in the referral form itself (seen in practice of one voluntary organisation in the UK).

> "*Sometimes you find kids that come along and the parents have been nervous and haven't known what to say to the child and felt they would be too upset, so kind of helping them* (referring to parents or carers*) think about their child and what would be best for their child, in terms of how to explain where they are coming and what's going to happen when they come here, as well."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

Although all professionals in the UK conceded to the voluntary engagement of children in therapy, there was lack of consensus on the latter i.e. the necessity for the child being aware of the reason for referral. On the contrary, a professional observed no difference in therapeutic outcomes for children who came for therapy with this awareness and those who didn't.

Therapists' Factors: **Role and Competencies of Therapists for Enabling Engagement of Children in Therapy and Facilitating a Therapeutic Relationship:** Building a therapeutic alliance was considered to be a conscious step that all professionals undertake and need for training and skills in doing so was emphasised. For developing a therapeutic alliance, ability of the therapist to *"*create a

containing relationship" and establish a "human connection" was considered critical by some professionals in the UK. These professionals recognised that while they assessed safety and receptivity of child and adolescents survivors of CSA to engage in therapy, children also assessed if it is safe for them to reveal their suppressed, hidden and challenging traumatic experiences to the therapists. It seemed to be in some ways linked to the child's ability to trust an adult's capacity to deal with their difficult and traumatic issues. When the child feels comfortable, and trusts that the therapists would be able to listen and hold his/her traumatic experiences without judgment or fear, they are able to open up. This was referred to as "containment" by some professionals, "love, compassion and complete acceptance" of the children and their traumatic experiences by others. Some professionals considered this as the ability of the therapist to form a "human connection" with the child and adolescent survivors.

> *"The child has learned very quickly that certain areas cannot be tolerated by significant adults in their life and so they don't actually explore what they need to explore. So they need to find somebody who can deal with these difficult issues before the child can actually process it."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

> *"Em, Sometimes I think that the role in all the work, regardless of the age, even if I'm working with parents and carers, is containment, and I kind of see that as being a very, very big part of my role is to provide containment…, that theory of Bion's about being a container for the other person."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

Some professionals argued for procedures to be adopted to ensure child's confidence in the professional's ability to contain the child. Hence, *maintaining "continuity" and "consistency"* in therapeutic practice and procedures was also considered critical. This included setting up rules or a verbal contract about weekly appointments: "same place, same time, same day and same therapist". These procedures apparently held the child safely within the "boundaries of space, time and same therapist" leading to stronger therapeutic relationship, as well as child's commitment to the therapeutic process with increased trust, security and confidence.

> "*And always, we made a point of telling them that the appointments would be weekly and at the same time so that we could build up a sense of trust and security.*" (Clinical Psychologist 2, CSA Specialist Service 1, UK)

While many professionals agreed with ***the therapists' quality*** of containing the child, not many agreed with the ***procedure*** of adhering to strict weekly appointments as mentioned above. On the contrary, some professionals in the UK reported difficulties even in engaging children in therapy on a regular, on-going basis. They found it difficult to enforce it, due to chaotic lives usually these children with complex trauma including sexual abuse, live. They shared their challenges associated with ensuring continuity due to often missed sessions and/or drop-out of children from therapy.

> *"I guess it's really hard with these young people because they are quite chaotic and vulnerable…, the way I look at it - in a block. I know that some are messed and in between to cancel, some didn't come to others. So she was a bit all over the place* (referring to a case of 12 year old girl)*, we did have to reschedule and I guess its knowing that and being ok with that."* (Clinical Psychologist 1, CSA Specialist Service 2, UK)

Another professional indicated practical resource-related and administrative challenges with it. In addition, being flexible with the therapist who would work with the child over time during therapy to accommodate specific needs of children was also emphasised.

Overall, being able to form a containing relationship apparently marked an important beginning in establishing a therapeutic relationship, but seemed to continue throughout the therapy process particularly during the next trauma-specific therapy phase. Hence, it was considered essential to establish a strong foundation during the initial stabilisation phase.

6.3.2.1.2 Therapeutic Approaches for Ensuring Internal Safety and Stability

Building a Therapeutic Relationship or Rapport Formation through Creative Therapies or Outlets: With regards to the therapeutic approaches, "creative

therapies" or "creative outlets" have been considered to be the most helpful in "breaking the ice" initially. Creative therapies were defined as:

> *"Creative stuff would be all the art material – play ya, drawing, painting, clay, using sand, using figures or doll's house, characters, animals, puppets, stones, shells. Umm, you could use really anything to be creative with.. It also includes board games like frustration etc."* (Art therapist, CSA Specialist Service 1, UK)

It encompasses the practice of art, play, dance, drama, music, story-telling, board games, crafts activities or any other such creative medium, practiced individually or in combination, by therapists trained in such a discipline. The practice of creative therapies was found uniformly across most professionals in India and the UK in this initial phase of therapy to engage children and establish trust. However, a higher number of trained professionals in creative therapies were found in the UK, in either one of these disciplines, such as art or play therapy, or combination of these. Only one professional (clinical psychologist) trained in play therapy was found in India. Influences of different psychotherapeutic schools were found on these creative therapies being practiced for establishing a therapeutic relationship. These included psychodynamic, human/child-centred, and integrative practice i.e. combination of different schools of thought.

> *"To be honest, we would get about ten minutes to begin with, where he would actually pay any attention to me because I had to earn his trust. So for a long time, we would sit in his room and I would play with his toys with him and try and enter his world*." (Therapist, Voluntary Organisation 3, UK)

The other spectrum of the practice of creative therapies identified was the use of ***creative outlets,*** as referred by a practitioner in India. It refers to the practice of similar approaches such as play, art (commonly referred to as drawing by these professionals), music and story-telling, however more based on practitioners' understanding, experiences and intuition rather than training. In practice, it takes more a form of drawing, paint, role plays, games, and discussion on hobbies and interests of children. In order words, it can perhaps be referred to as general '***play-way'*** of engaging children by professionals who are not trained or qualified to

practice any of the creative therapies mentioned above. The practice of 'creative outlets' was observed by a number of professionals in India and few in the UK.

> *"I often break the ice with the child by talking about their favourite game or cartoon; I keep myself abreast with different age groups, what are they really liking and doing. A lot of discussion on that and what do you do; and you have a lot of technology support nowadays where you can probably show them a game in which they enjoy doing and things like that. And that probably strikes a chord with them*." (Clinical Psychologist 2, Hospital, India)

Creative therapies or outlets were found to be practiced with both younger and older children to facilitate their engagement in therapy. While play and art were used more with younger children (though not exclusively), use of board games, crafts-based activities, or discussion on their hobbies or interests was being practiced with older children. However, this was not a rule. Thus, professionals believed in supplying adequate creative materials in the room to adequately engage children of any age. Extensive play room or "creative therapy rooms" were seen in the UK than in India. This included variety of material such as wendy-house, sand, clay, colours, basins with water facility, puppets, toys and different games.

> *"If you try to meet them* (children) *where they are and be prepared for some of these things and supply the room with things like babies... or arts and crafts materials so they can share with you, and you are also not giving them the message, 'oh well you are 18 so you should be talking about it', because that 18 year old may you know might have such a horrendous upbringing*." (Play Therapist, CSA Service 2)

The practice of creative therapy was evident uniformly, although the professionals interviewed acknowledged that all the therapies practiced under the broad umbrella term of creative therapies or outlets including art and play lacked the evidence-base.

Normalising Feelings and Restoring Normalcy in Life through Psychoeducation*:* Normalising feelings of self-blame, shame, guilt, betrayal, sense of alienation and low sense of self and low self-worth that most children experience due to CSA was considered an important step for stabilising children and to help children open up.

> *"So initially when she first came to our service, we spend about a time just actually talking about her* abuse *and some of the feelings she might be left over with, the kind of shame, the guilt, betrayal and for parents"*(Clinical Psychologist 1, CSA Specialist Service 2, UK)

Psychoeducation emerged to be one of the key therapeutic approaches practiced to frame CSA in context as well as provide reassurance and positive messages in order to normalise their feelings towards self and others including parents. This included providing correct and complete information to the child about the dynamics of CSA including how perpetrators operate; secretive nature of it and that 'they are not the only one'; impact of CSA; grooming process; and sexuality, sexualisation and its association with CSA.

> "*And that's where she (*referring to a 10-year old sexually abused girl) *started saying that first when he started doing these things to her, she didn't understand the meaning. Then she became more curious. Then somewhere she started liking it. She admitted that. You know that was one source of guilt, So once it was revealed, I mean, explained to her that look, it is natural. Because sexual sensations, sexual fantasies, the psychosexual development, as it takes place. So all these issues are part of development, basically. So once, something that is natural is combined with emotions, it can get messed up. So she was intelligent enough to understand these things*." (Psychiatrist 1, India)

By providing complete and correct information about CSA and how the perpetrators operate, the professionals addressed the meanings attached to it by children by clarifying the misconceptions held about CSA and their (children) own experience of it.

> *"We then need to help them understand, give them a consistent narrative about what happened. It's more about the truth than the story they were probably told… "Therapeutically, what we want is children to get the message that, "This wasn't your fault – you're not the bad one."* (Practitioner, Voluntary Organisation 4, UK)

Restoring Normalcy in Life and Building Self-Esteem through Engaging Children in Constructive Activities: This was another intervention that the professionals in India considered therapeutic for child and adolescent survivors of

CSA. This enabled the professionals to address the feelings of isolation and alienation felt by children. These professionals asserted that many families socially isolated the child either due to the concerns of safety or protection of children or because of shame and fear of stigma. This was considered to affect their self-esteem adversely, leading to "internalisation of trauma" and possibly causing post-traumatic stress symptoms. Through "engaging children in constructive activities", they aimed to "restore normalcy" in child's life, and thereby facilitate creative thinking, assertiveness skills, build self-esteem, self- awareness and overall sense of self.

> *"What happens is many families wrongly, or many caretakers normally, would actually push the child into a very alienated environment, thinking that that will be safer for him* (child). *No, the child has, actually, to be back to school, the child should be back to his peer group, the child should be, ideally, back to the play way, right! Even right back to the most trusted people in the family, and, so-called normalcy of the life restored."* (Psychiatrist 3, India)

> *"So initially, the short term goals were built around building her* (referring to a girl survivor)… *self-esteem, so making her join in some classes, making her do certain things, taking up responsibilities…, which helped her to raise her self-esteem and confidence a little bit."* (Therapist, Voluntary Organisation 7, India)

Besides including child's regular activities such as going back to school and peer group, other examples of constructive activities provided by the respondents included engaging children in meaningful activities and hobbies such as games, music, dance and other such interests of the child". This intervention was considered critical for facilitating "emotional recovery" in children. In this context, "emotional recovery" was defined as:

> *"When we say emotional recovery, we mean reinstatement to the regular lifestyle and helping the child to be more assertive."* (Psychiatrist 3, India)

Assessing and Treating Self-Harm and Other Severe Presenting Difficulties through Psychiatric Assessment and Pharmacological Interventions, Creative Therapies and Psychoeducation: Psychiatric assessment and pharmacological

treatment was found to be in practice both in India and the UK, although limited largely to children presenting with severe symptoms and difficulties. Examples provided of such severe difficulties warranting pharmacological interventions included self-harm, depression, sleeping problems, severe physical violence or aggression, and other psychosomatic or biological symptoms. It was considered necessary to address these difficulties to stabilise children before they could be engaged meaningfully in therapy. However, in some cases, this continued concurrently with therapy. Sometimes, in the UK, this intervention began while the child was on wait-list for therapy.

> *"We're seeing a seventeen-year-old at the moment. We finished the assessment and diagnosed her with depression, she's also got sleep problems, lot of physical health problems, panic attacks, so she was being seen by one of the doctors, trainee doctors to review. Uh He prescribed melatonin for sleeping, he was reviewing the medication, but she was also on the waiting list for CBT with our counsellor."* (Social Worker, CSA Specialist Service 3, UK)

If the initial assessment indicated that a child required medication/and or hospitalisation, then this was considered to be a priority over therapeutic intervention till the child was stabilised enough to engage with CSA-therapy.

> "*In some instances, if the psychological symptoms are severe and if they require hospitalisation, we will definitely admit the child to our inpatient facility and we will continue to provide the therapeutic support or whatever required for the child."* (Psychiatrist 2, India)

While there was largely a consensus seen in favour of a psychiatric assessment when the child was perceived at the risk of self-harming, suicidal ideations or other severe symptoms, the professionals emphasised the need for trauma understanding and sensitivity of psychiatrists to be aligned with that of therapists working with children. However, most professionals, in India and the UK, found it challenging to find the same.

> *"So, yeah, in an ideal world, I love to have a multi-disciplinary team (*referring to the inclusion of a psychiatrist the team), *but it's very dependent on the attitude* of *the psychiatrist. And we still have quite a few*

that don't think in the same ways." (Therapist, Voluntary Organisation 3, UK)

Similarly, most NGO professionals in India were quite critical about the mainstream mental health services in hospitals including psychiatric services about their over-emphasis on the medical model including psychiatric assessment and labelling through a psychiatric diagnosis and pharmacological treatment. These professionals, both in India and the UK, argued for timely and appropriate therapeutic interventions compared with pharmacological or psychiatric intervention to help children understand the cause of such symptoms and provide alternate ways to deal with them.

*"But if it is known that she is self-harming, something that we are working with, I try to remove the panic out of it. I don't think we need to panic about things like that because what I would be interested in, to find out what it means to them…, this behaviour, whatever the behaviour it is. So it's self-harm, what need are they meeting through self-harm? And there is then other ways of meeting that need, more healthy way or more in a relational way with someone else, you know. That will be the basis for whatever I do next." (*Therapist, Voluntary Organisation 1, UK)

Hence, **creative therapies or outlets** were also being practiced and preferred by some professionals interviewed to address these difficulties such as violent behaviour and dissociation in order provide children alternate ways of expressing and meeting their needs. While creative therapies were found to be more appropriate with younger children, **Psychoeducation** was also described as a therapeutic practice to address symptoms such as dissociation in older children.

"When children are older, I will always explain to them what I think has happened in their mind, why they dissociate, what happens in the brain." (Practitioner, Voluntary Organisation 4, UK)

Overall, the findings indicated that some severe symptoms and difficulties, particularly self-harm, needs to be addressed as a priority to facilitate emotional stability and better engagement of children in CSA-trauma therapy. However, from the variations in perspective and therapeutic approaches discussed above to address

severe symptoms or difficulties, it is inferred that there is no one way of doing this. It is apparent from the above discussion that there are two distinct set of professionals, both in India and UK. Some of them followed psychiatric and pharmacological interventions or some children responded better to this. Others argued in favour of psychotherapy using varied approaches such as psychoeducation and creative approaches. According to these professionals, these therapeutic interventions led to symptoms-reduction and/or children learnt to manage these symptoms better.

To conclude, it is evident from the above analysis that a number of domains are addressed to secure emotional stability in children such as building a therapeutic alliance, normalising feeling and functioning, and controlling the severe symptoms and difficulties as a priority. In terms of therapeutic approaches, largely creative therapies or outlets seemed to be practiced uniformly to address all these domains both in India and the UK. However greater influence of the therapeutic factors, including therapists' competency and therapeutic principles and procedures, was apparent for building the therapeutic alliance with children.

6.3.2.2 Stabilising Children through Supportive Therapy: Engaging Safe Parent/Carer to Enhance Support for the Child

The aim of the 'Supportive Therapy' is to enhance support for the child by engaging families, primarily the non-offending parent/carer (referred to as safe parent). All professionals in the UK engaged the family, primarily non-offending parent/carer in addition to undertaking direct therapeutic work with the child. While the professionals in India attempted to engage families/identified trusted adult in therapy, it was not always possible.

> *"So the parents will have some influence on how the child was abused, whether they were there or not, and then they'll have a huge influence on the child's experience of telling, being believed, getting support. So working with the parent, it's almost like* ***boosting*** *everything in the child's life, if it's the parent the child lives with. I think it's much more robust and any support we're putting into giving to the child is going to be really doubled because the parent is also getting support." (Therapist, Voluntary Organisation 1, UK)*

"So, the biggest asset I find in our culture, though paradoxically enough, in many situations, is the family. But what missed out was the right person in the family who never came to know. So, tapping the right person, like the mother, who can be a wonderful safety net for the child, and helping that mother to take on the support therapists role or therapeutic role is a wonderful conveyor belt available to pass on both the instructions and both the areas of intervention." (Psychiatrist 3, India)

6.3.2.2.1 Therapeutic Approaches for Supportive Therapy

Psychoeducation with Safe Parent/Carer: Psychoeducation on CSA or "socio-educative work (as termed by a professional in the UK)*"* emerged to be the main therapeutic approach practiced with safe parent/carer to stabilise them, facilitate their engagement in therapy, and set realistic exceptions of parents from the therapists and vice-versa. The initial sessions with the parent/carer (who was usually the mother in both India and the UK) addressed their anxiety and prepared them for in-depth supportive work that they are required to undertake during the ensuing trauma-therapy phase. This is also in many ways akin to preparing the parent to engage as a 'co-therapist' to ensure adequate support for children within and outside the therapeutic setting.

"At the same time, we would uh have another worker working with the carer, to help in similar ways – to process it, socio-educative work, and think about how they might support their child. And within that, there will be some sort of capacity to say how much can they do, how much can we do formally, how much will they be doing at home." (Therapist, Voluntary Organisation 2, UK)

Therapeutic intervention for stabilising families/safe parent included normalising their distress, self-blame, and guilt around their child being sexually abused; addressing their lack of belief and tendency to blame the child (mostly in India but sometimes in the UK as well); contextualising CSA by providing complete and correct information; and lastly, supporting them to enhance support for the child. In this sense, containing the safe parent was considered an important part of their role as therapists.

> *"Dad was very anxious about letting the son go, so he was, dad was as anxious as the child, almost. So it didn't feel like that was very containing, so, actually, I felt like I needed to contain dad, as well."* (Social Worker, CSA Specialist Service 3, UK).

Professionals in India also highlighted their additional focus on addressing stigmatisation attributed to CSA as well as issues of sexualisation linked to it.

> "*And in the second case, actually the parents tell them that, probably, he's enjoying all of that. So, making them understand that he doesn't even know whether this is an act which is to be enjoyed or what. I mean, the enjoyment has to come later, it has not registered to him."* (Clinical Psychologist 2, Hospital, India)

Sexually inappropriate behaviour was a concern that came up almost in all interviews in the UK as well. This was discussed as an emerging theme in the interviews, however later was not pursued for three reasons. One, there was a lack of consensus amongst professionals on clear association between CSA and sexually inappropriate behaviours in all cases. Reasons other than CSA have been attributed to sexually inappropriate behaviour as well. Second, sexually inappropriate behaviours especially towards others raised concerns about legal and criminal responsibility of a child being looked upon as a perpetrator of abuse. Lastly, all agencies in the UK interviewed for the study, both statuary and voluntary sector, had separate therapeutic services with different teams for children who had been sexually abused and for those who were referred for sexually inappropriate behaviour. The latter usually covers children between 10-17 years of age, perhaps corresponding with the age of criminal responsibility of children in the UK. The professionals from these teams confirmed different strategies and criteria for working with children with sexually inappropriate behaviour than those with CSA-trauma. For these varied dimensions, studying the therapeutic interventions for children with sexually inappropriate behaviours was considered beyond the scope of the current research.

6.3.2.2.2 Therapeutic Factors for Supportive Therapy

Therapeutic Procedures: While the therapeutic approach of psychoeducation was practiced both in India and the UK, one major difference in the practice of supportive therapy was noted in the therapeutic procedures followed by professionals in these countries. Considering the issues of trust, confidentiality and possible family difficulties due to CSA, most professionals in the UK ensured a different therapist for the child and parent/carer respectively, particularly with older children. However, in India, mostly the same therapist worked with both the child and parent, with an exception of one voluntary organisation, where they attempted to follow the same procedure as in the UK. In India, professionals emphasised joint working where possible, considering the social ethos of a collective and other cultural factors. In case of very young children, professionals both in India and the UK, usually worked only with the non-offending parent(s)/carer or worked with the child in partnership with them.

Hence, interventions in this phase were found to be helpful for children and their families as well as for the professionals themselves in facilitating engagement in therapy and establishing a therapeutic relationship.

> *"That kind of thing helps* (professionals), *but it also helps them* (children). *In the beginning, it might not, you know, they're all over the place. But eventually, that's something that we do notice, the changes in the child*." (Therapist, Voluntary Organisation 2, UK)"

6.4 Transition of 'Stabilisation and Resilience Building Phase' to the Next Phases of Therapeutic Interventions

Although 'Stabilisation and Resilience Building Framework' emerged to be the first phase in therapy, professionals considered it significant in the entire therapeutic process and it continued throughout the other phases of therapy. A number of processes that get initiated during the stabilisation phase continue and get reinforced throughout the trauma therapy. For example, children may feel anxious a number of

times during CSA-trauma therapy (next phase) and may require to be contained over and over again, especially when they engage with difficult or suppressed trauma memories and experiences.

> *"It is about repetition of experience, which is one of the reasons why in this kind of therapeutic work, doesn't tend to be short term because the relationship experience needs to happen and the containment needs to happen again and again and again and again."* (Clinical Psychologist, CSA Specialist Service 1, UK)

This phase was considered integral for building the foundation for next phase of trauma-specific therapy, however it may not be a linear movement from this phase to the next in all cases. There may be a back and forth movement from one phase of therapy to the other, depending on the situation and circumstances of children.

> "*If they've cut or self-harmed, you might need to stop your trauma focused work and stabilise them a bit."* (Psychiatrist, CSA Specialist Service 3, UK)

On the other hand, this phase was found to be the only therapeutic intervention in most cases in India. One of the reasons for the same was attributed to the cultural factors discussed earlier. Second, this phase was considered to be a complete intervention by itself by some professionals if the key aims of securing physical and emotional safety and building resilience and sufficient protective factors around the child were met. The latter also seemed to address the cultural factors by engaging families and breaking the silence around CSA.

"Safety. Just safety I mean I can, any of these girls can survive. You know even if they do not work on the traumatic memories, they will survive if they feel safe, internal inner safety as well as external safety. So if you feel safe in my current situation inside in my body now. Presently if somebody helps me to make sense of my symptoms and make me feel inside how to achieve that safety inside, and if I do not get an opportunity to work on my traumatic memories, I would still manage." (Independent Trauma Therapist, India)

"To conclude interventions, I think these are the allied issues - personal, family, social and also, maybe a little bit of occupational because many of them stop going to school – should be worked upon if we need to bring about a comprehensive enrichment of this victim, from the societal point of him." (Psychiatrist 3, India)

This may be the case sometimes in the UK as well when sometimes children did not feel ready to move on to the next phase for CSA-trauma resolution or parent(s) may stop bringing the child. In such cases, both in India and the UK, this phase of therapy may lead directly to the fourth phase of interventions i.e. 'Maintenance and Relapse Prevention'.

"It may be, some people have an assessment which is for four weeks, initial four weeks and they say they don't want to come back because they've had enough or they've done all they need to do or they can't do more, for whatever reason." (Therapist, Voluntary Organisation 1, UK)

This, yet again, highlights the significance of flexibility in approach, duration and overall engagement of the child in the therapeutic process based on the needs, circumstances, and receptivity of children. It also highlights the significance of this 'Stabilisation Phase' by itself – as a major and sometimes a stand-alone therapeutic intervention for many child and adolescent survivors with some inputs from the fourth phase for prevention of relapse and victimisation.

Similar concerns about flexibility also emerged in analysis of responses regarding transition from this phase to the next. The transition from one phase to the next may not be immediate, depending on the situation and circumstances of each child. Need for ongoing assessment and appropriate breaks in therapy as required were reiterated by professionals. An assessment at this stage helped the professionals to decide if the child was ready or the timing was right for the child to move on to the next phase.

Lastly, as evident, it is quite a critical intervention in the entire therapeutic process, it was also expressed to be quite challenging both for child and adolescent survivors as well as for the therapists themselves in India and the UK.

> *"I think it's very hard to engage people because I think the work is so hard for patients. Some of the engagement issues are very challenging, really. And often the families are quite dysfunctional."* (Psychiatrist, CSA Specialist Service 3, UK)

> *"The rapport building is the most difficult part, but definitely with these, they know that probably, 'that is something which she knows about and she will talk to us." And when that doesn't happen, and when it's all normal stuff, fun stuff with them – at the same time, helping them with their difficult areas – they respond positively."* (Clinical Psychologist 2, Hospital, India)

Due to these challenges, the professionals acknowledged that stabilisation phase including assessment may take a long time to get children to a point of comfort and receptive to the next phase of therapy. All professionals interviewed agreed that the stabilisation phase itself can often spread over months to year(s), although the exact duration varied from one case to another. This establishes the long-term, yet flexible, nature of trauma therapy. It is further inferred that the therapists need to stay mindful of the stabilisation needs of children, and invest time and energy in this phase. It is considered critical for better outcomes from CSA therapy for children.

> *"So we might spend 2 or 3 sessions getting to know them, using these kinds of tools. Um, and it depends, I mean, some, like one girl, it's taken her almost over a year to get to this point where – and she had a gap at one point – where she can start to talk about it* (referring to readiness to talk about the CSA trauma experienced)*."* (Psychiatrist, CSA Specialist Service 3, UK)

6.5 Stabilisation and Resilience Building Framework: Conclusions, Discussion and Summary

The significance of stabilisation prior to starting trauma-specific therapy has been recognised in the findings as well as in the literature (Courtois, 1997). The outcome expected and observed by the therapists at the end of this phase is a stabilised, stronger and rooted child with a higher level of trusting and comfortable relationship with the therapist, which forms the foundation for the next stage of therapy for addressing the CSA trauma.

Table 6.1: Summary- Stabilisation and Resilience Building Framework

Intervention	Stabilisation and Resilience Building	
Key Goals	To stabilise and build resilience of child and adolescent survivors of CSA in order to secure external safety and stability, build inner strength or internal safety, and ground them for ensuing difficult and challenging trauma-specific therapy.	
Key Therapeutic Interventions	**External Safety** • Multi-Agency Collaboration (UK) • Child Focussed Interventions: - Psychoeducation and Role Plays (India) • Supportive Interventions: - Engaging safe parent(s)/carer or other identified trusted adult (India)	**Internal Safety or Inner Strength** • Adherence to Therapeutic Factors: Procedures, Principals and Therapists' Role and Competences (India and UK) • Child Focussed Interventions - Creative Therapies or creative outlets (India and UK) - Psychoeducation (India and UK) - Engaging in constructive activities (India) - Psychiatric Assessment and Pharmacological Interventions (India and UK) • Supportive Therapy (India and UK)

A combination of therapeutic approaches and therapeutic factors are practiced during this phase of therapy by all professionals. Largely similarity and consensus on the type of therapeutic approaches practiced have been found among all professionals in India and UK, with some variations. Creative therapies and psychoeducation are practiced by most of them. Engaging in constructive activities and building assertiveness skills are additional interventions primarily seen to be practiced by professionals in India. Further, conflicting views with regards to psychiatric intervention and pharmacological approaches have been found, with a number of professionals favouring practice of therapeutic approaches rather than a medical-based, pharmacological approach. Lastly with regards to the therapeutic factors, there are similarities in the therapeutic principles upheld by all professionals whereas some variations in practice of therapeutic procedures have been found.

Assessment of child's situation and history-taking is done simultaneously as the efforts to stabilise the child are being made. This assessment feeds into some of the concerns of the therapists related to the stability, security and safety of children. This assessment, besides helping the professionals to take decisions regarding the treatment plans of the child, it also facilitates decision about the intake of the child in therapy, primarily in the UK.

However, the analysis of interventions in this phase also raises some concerns that indicate some possible limitations. One, there is a concern regarding the therapeutic decision primarily in the UK about not engaging children in therapy if the family or supportive environment is not considered to be safe or stable. At one level, while it is understandable as the respondents believed that therapy in such situations would not be effective and that the child may not be receptive. Similarly, CSA-Specialist agencies do not accept children for therapy if CSA is not disclosed and investigated and most often self-referrals are not accepted by most of them. These aspects raise a challenge about child's right to participation and engagement. Child's right to participations has been granted by the United Nations Convention on the Rights of the Child (UNCRC, 1989) that has been ratified by the UK in 1991. It is inferred from the analysis of responses of professionals in the UK regarding decisions of the intake of children in therapy that a large responsibility of the child including decision-making for their well-being and participation is placed on the parent(s)/carers and/or referrers as well as professionals/therapists themselves. Further, "most UK studies of sexually abusive children show high levels of family dysfunction" (Vizard, 2006, p.77, cited in Allnock et al., 2009). Based on this, it can be speculated that if a stable parent(s), family situation and environment is considered critical for accepting children for therapy, most children in the UK may not find a place in therapeutic services. Further, it is inferred that the child is being rejected from therapy after a few sessions of assessment, usually 3-5, which perhaps further leaves the child with a sense of abandonment and rejection. This possibly could leave the child further traumatised. Lastly, it perhaps remains to be deciphered if this therapeutic decision is out of concern for the child or the service itself in order

to ensure effort and resources to be invested where possibility of positive outcomes is high. However, in absence of evaluation/audit of services and their interventions provided to children who have been provided therapy as well as those who were rejected, it is difficult to ascertain the viability of these decisions from a therapeutic interventions perspective. The need for children to access services through adult gatekeepers is recognised to be a barrier for accessing therapeutic services for CSA in the UK. In a recent review of service provision in the UK, the young people interviewed expressed the desire to participate in decision-making about the therapeutic services for them (Allnock, et al., 2009). Further, they shared a preference to self-refer, and access guidance and support confidentially before undergoing any therapeutic intervention (Allnock et al., 2009; Domakin, 2011).

Hence, it is concluded that while engaging the families/safe parents or carers is critical, perhaps there is a need to be mindful of the overemphasis on parents/carers as 'gate keepers', which sometimes seems to become a barrier for children in accessing therapeutic services, both in the UK and India. Further, specific needs and expectations of these children and young people (both who are accepted for therapy and those who are not) would have implications for therapeutic interventions practiced by the professionals. These voices of child and adolescent survivors for their well-being and decision- making need to be heard more prominently in research studies in order to inform services and their therapeutic practices.

Second, in the Indian context, a concern is raised about the need for comprehensive multi-disciplinary and multi-agency services for child protection in general and CSA-therapy specifically. In absence of this, the professionals in India end up dealing with a host of issues in therapy in order to stabilise the child including external and internal safety and stability. This highlights the need for culturally sensitive, multiple layers of interventions and services working jointly in India to provide holistic care and services to the child, such as in the UK. This includes specialist trauma therapy service provision where the therapists can focus on providing the therapeutic intervention while other external/environmental concerns can be handled by other service layers.

Chapter Seven

CSA-Trauma Resolution Framework: Integrating the Fragmented and Traumatised Child

'Trauma Conceptualisations and Pathways to Therapeutic Interventions'

"Children can get stuck in trauma, that trauma can impact on them and they can get emotionally stuck. So that, some children may resolve this issue through the therapeutic work that you are doing."

(Therapist, Voluntary Organisation 2, UK)

7.1 Introduction

Following the 'Stabilisation and Resilience Building' phase, this next phase involves CSA trauma-specific therapy for child and adolescent survivors. The understanding of this phase was gained through the practice of all professionals in the UK and three in India. This chapter presents the child traumatic stress factors that lead to a 'fragmented and traumatised child' and forms the understanding of the professionals for practice of this phase of CSA-trauma therapy. Further the significance, rationale and critique of different therapeutic approaches practiced by the professionals to address the traumatic stress in child and adolescent survivors are discussed.

The main goal of this phase of therapy identified by the professionals is to facilitate recovery from CSA trauma by helping the survivors achieve better self-integration and revival of normalcy and optimal functioning. Different terms were used by professionals to describe this phase of therapy, such as "recovery", "healing", and "trauma resolution". For example, healing was defined by one professional in India as:

> "*When I say healing, it basically refers to a process wherein we try to address these issues and aa try to look at these various sequelae of abuse and try to ameliorate those sequelae and also ensure that the child attains an optimal level of functioning and it involves actually working with the child so as to aaa make the child overcome these sequelae of abuse."*
> (Psychiatrist 2, India)

7.2 Professionals' Frame of Reference

This section is divided into two parts. In the first part, professionals' understanding about the need and significance of this phase of CSA-Trauma Resolution Framework with child and adolescent survivors is discussed. This is followed by the discussion about the variations in trauma conceptualisation of different professionals or agencies they were associated with, which to a large extent influenced the specific therapeutic approaches adopted by them with survivors in this phase.

7.2.1 Professionals' Frame of Reference Reflecting the Need and Significance of 'CSA-Trauma Resolution Framework': Child Traumatic Stress and Social Factors

Although providing CSA therapeutic service is the core remit of the agencies in the UK, a shared understanding emerged among professionals in India and the UK for the need and focus of this phase of CSA-trauma resolution therapy. It includes their understanding about child traumatic stress and social support needs of child and adolescent survivors of CSA during CSA-trauma therapy.

7.2.1.1 Child Traumatic Stress Factors

Professionals recognised that CSA leaves a deep impact on children that need to be talked about, processed and integrated to facilitate recovery or trauma resolution. Child traumatic stress is defined as the reaction to a traumatic event(s) that interfere with the child's daily life and affects his/her ability to function effectively and interact with others (Franks, 2003). These reactions or difficulties experienced by children were discussed by the professionals who reinforced the need for therapeutic support.

Professionals, irrespective of the setting and country, receive referrals of children and adolescents for a combination of mental, psychological, emotional, academic and behavioural difficulties. Some of the presenting conditions and difficulties included anger, low mood, depression, self-harm, flashbacks, problems with sleep,

academic difficulties, problems at school including withdrawal from school, relationship difficulties and sexually inappropriate or worrying behaviour.

> *"I think from memory the disclosure came after she was really struggling at school, so really behaving badly, kind of missing classes and that's when kind of she was able to disclose, I think to a guidance teacher what was going on."* (Clinical Psychologist, CSA Specialist Service 2, UK)

> *"They come with symptom often trauma, mood problems, depression, so the commonest presentation on the severe end is symptoms of traumatic stress, symptoms of depression, symptoms of anxiety."* (Psychiatrist, CSA Specialist Service 3, UK)

The nature of complex trauma including intrafamilial, prolonged, repetitive sexual abuse coupled with polyvictimisation has been discussed earlier. Based on this understanding, trauma therapy is considered critical to address the presenting difficulties in different domains of functioning.

For resolution of difficulties and stress reactions, professionals largely considered it important for the child to talk about and explore the traumatic experience(s) in some detail. Given the silence and secrecy around CSA trauma that suppresses children and hinders disclosure, some professionals considered it cathartic for them (children) to be able to talk about the abuse in a non-judgmental and safe therapeutic space. Although the socio-cultural factors that perpetuate silence and suppression were emphasised more strongly by professionals in India, a few professionals in the UK reiterated that children are affected by the "suppression and containment" of CSA within themselves.

> *"Now, I think it's important for a child in some sense, an adult for that matter, to be able to explore these issues in some way. Otherwise, all their psychological energy goes into containing and suppressing and they can't live a full life and they can't learn to trust. And you see many of these children have reading and writing difficulties because the energy is going into suppressing and containing, within themselves, all this horrible material that they cannot allow out, cannot sort out."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

Further, exploring the context and components of the sexually abusive experience(s) suffered helps the professionals in understanding and addressing the meanings children attached to the abuse. This was considered critical by professionals in facilitating trauma resolution.

> *"So to me, it's really important to have an idea, if possible, what meaning the child gave to the abuse. And certainly, I've worked with a number of children where they have been told, 'If you tell, something bad will happen to your mum. Something bad will happen to your little sister.' Or, you know 'God will be looking at you and punishing you'. Perpetrators will use any kind of manipulating silencing thing, which is very difficult for us to work with therapeutically. So, its' trying to find out, how were they were silenced and how do I work with that."* (Therapist, Voluntary Organisation 4, UK)

> *"In general, we encourage them to talk about it* (CSA) *in terms of being emm helpful, not from the sense of the way police want to know but more from the sort of sense of trying to find out about what the experience was like for them, what the thoughts and worries they had…, how it made them think about themselves and the world that sort of the more cognitive side really.* (Psychiatrist, CSA Specialist Service 3, UK)

It was considered all the more important when disclosure was never made prior to speaking with the therapist or when there is a suspicion of CSA but it had not been disclosed, which was unusual in the CSA-Specialist service system in the UK. For example, a professional from a voluntary organisation in the UK talked about a six year old autistic child brought for therapy on the suspicion of sexual abuse due to changes in his behaviour after returning from a summer camp. After the stabilisation process, therapy focussed on supporting the child to talk about abuse, which itself was considered to be cathartic. It became the key focus of the therapy in this case for the professional.

> *"We were encouraging him what tell meant to get across to him that it was always important to tell. Even if somebody said no, even if somebody told you to keep a secret, it's always better to tell."* (Practitioner, Voluntary Organisation 4, UK)

The findings discussed above indicate that clearly professionals agreed on the need for CSA trauma specific therapy for addressing the child traumatic stress reactions

and recognised the need for talking about the abusive experience in order to help children and adolescents process, integrate and heal from it. However, the detail to which it is discussed and how it is dealt with therapeutically in terms of the approaches practiced varied, based on the trauma conceptualisation of the professionals interviewed and/or the agencies they were associated with. At the same time, providing children an informed choice and respecting the decision and pace of the child in this matter seemed critical to the therapeutic process.

> *"In trauma focused work we would definitely want them to talk about it* (details of CSA). *Emm children vary in their level of preparedness to talk about it. So Emm so it's helpful to, them but we also say to them very clearly we are not going to force them to talk about anything that they don't want to talk about because you know that can be counter therapeutic, and they have already had coercive experiences so we don't want them to experience you as coercive."* (Psychiatrist, CSA Specialist Service 3, UK)

7.2.1.2 Social Support Factors

Supportive therapy was considered an integral part of this phase of therapy. This means engaging families including safe parent(s)/carer(s) and sometimes siblings and the larger social system of the child such as school, social work, and/or residential care worker. This practice is based on the professionals' understanding about the need for a strong social support or a "holding system" for the child during this CSA- trauma therapy phase.

> *"We also found, again, practice wisdom, that if the parent or significant carer believed and supported and was with the child through the work, in some way, that em there were better outcomes for the child… So we attempted to address the carer's needs… in relation to their child…, to help them better help their child, I suppose."* (Therapist, Voluntary Organisation 2, UK)

The key aim of family work apparently is to support them, essentially the primary safe parent/carer, to support the child during this phase of trauma therapy, which was considered to be difficult and highly challenging for the child. Professionals observed that the child's behaviour or condition sometimes worsened initially during

trauma therapy. Hence, it was considered critical to prepare the parent(s)/carers to provide the additional care and support needed by the child during this phase. At the same time, the professionals supported them in handling the difficulties experienced by the child in the home environment, outside the therapy setting. Professionals also believed that simultaneous work with the child's support system is important to ensure consistency in the messages provided to the child, within and outside the therapy setting.

> *"If you're teaching them* (children) *how to protect themselves, you've got to make sure that same message is being done at school and at home... because the times when they will have flashbacks or they dissociate or they feel most vulnerable will probably be at night-time, so I need to work with carers to say, how are you gonna work with them in the middle of having a nightmare or night terrors?"* (Therapist, Voluntary Organisation 3, UK)

Engaging the larger social system of the child such as school, social work, and/or residential care worker was found to be another integral part of this phase of trauma-therapy, both in India and the UK.

> *"There is work with the school, as well, because often the schools have difficulty in appreciating how impaired some of these children are and they often have more internalising problems. So the can be sort of be misread…they are kind of quietly suffering."* (Clinical Psychologist, CSA Specialist Service 2, UK)

Similar to the cultural factors in India, most professionals confirmed that there was a general lack of understanding of CSA in the UK among other stakeholders, including care givers, service providers, social workers and staff at schools. At times, apparently they failed to understand the impact of CSA on children and as a result, the child's emotional and/or behavioural difficulties were not understood by them and often children were labelled and blamed for such difficulties.

> *"What it is, more specifically is, if I'm having a phone call with a worker who's working with the child and I'm talking to them about, maybe they're giving me an update on how things have gone that week. And the language that they're using about the child, I'm thinking, 'Oh,* no, this is *what the child's hearing at home or in a residential unit.' So that's where*

it's connected. I'm hearing it from either a parent or a worker and then my job is also to try and explain to them." (Therapist, Voluntary Organisation 3, UK)

Hence, the main objectives of the interventions with the social system were to sensitise them about the CSA-trauma and associated difficulties experienced by children, and consequently, foster greater understanding, support and management of child and adolescent survivors. All professionals asserted that the therapeutic outcomes for children are better if they receive adequate support from within the family and other support system during therapy.

7.2.2 Professionals' Frame of Reference Governing the Therapeutic Approaches Adopted: Trauma Conceptualisations

Although children were referred for CSA therapy, by and large, with similar difficulties or 'stress reactions', variations in therapeutic practice or approaches adopted by different professionals for addressing these were found. The findings of the study indicate that these variations in therapeutic approaches can be largely attributed to the conceptualisation of CSA trauma by different professionals or the agencies they were associated with. Three key modes of conceptualising CSA have emerged: i. Construct-based conceptualisation; ii. Symptom-based conceptualisation; and iii. Developmental stage-based conceptualisation.

7.2.2.1 Construct-based Conceptualisation: Conceptualising CSA as a Relationship-based Trauma - Rebuilding Child's Relationship with Self and Others

One set of respondents, primarily in the UK, conceptualised and addressed CSA as a 'relationship-based trauma' with a deeper level of damage on child's sense of self and world view, and consequent ability to form meaningful relationships. Given that most of the sexual abuse experienced by children is intrafamilial in nature by a trusted adult and that many children come with multiple-victimisation including neglect, the relationship-trauma based conceptualisation seems a consonant therapeutic perspective.

> *"For many of them* (survivors)*, you know, the trauma, it is relationship-based trauma and it might not just be about the actual act of sexual abuse itself. It's about all the confusion and betrayal and trust issues around that, the difficulties in the relationship and how others have responded to that and either protected or not protected, or believed or not believed."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

> *"If they've been so severely abused, they might not have a social brain. We have to help them to read other people and to act appropriately, so I'm also informed by that."* (Therapist, Voluntary Organisation 3, UK)

The professionals with this trauma conceptualisation seemed to adopt the therapeutic approaches that could help them address relationship issues and facilitate relationship-building. These professionals seemed to focus on understanding and addressing the meaning attached to CSA by children, and how it affected their perspective of others (primarily other adults) and sense of self.

> *"I think what is essential is that the person who's been abused is able to repair the basic ability to relate – that relationships, both within their inner self and with other people. Emm they need to be able to develop a trust, they need to be able to relate to others, not just about abuse, but across a range of things. That's what I think is the most vital part of therapy."* (Clinical Psychologist 2, CSA Specialised Service 1, UK)

> *"If you look at grooming, things around grooming, in the way how it happens, there's a relational aspect to it. So in order to understand it, the impact and what the child takes away from it relationally, which is how they then relate to the world outside, that I think that's what you have to work with."* (Therapist, Voluntary Organisation 1, UK)

The above conceptualisation reflected the professionals' understanding of how trauma affects children, both the impact on self in terms of their emotions, body, attachment, overall world view as well as their ability to form relationships with others. At the same time, professionals recognised that CSA not only leaves its impact on the child who suffers it but also affects the family members and their relationships in different ways, especially if there were stresses prior to the child's sexual abuse. Hence the focus of interventions is to help the child process the trauma and improve relationships with family members and others socially.

"Some of the research talks about the carer-child relationship being affected adversely by the sexual abuse in the family. You know, if it's a boyfriend or a family friend, the parent may feel responsible, they may be angry with their child because although they know, you know, they might have the right reasons… feelings that it shouldn't have happened to their child, but they still harbour that kind of ambivalence or whatever… So if there is something, so you can help them relate to each other." (Therapist, Voluntary Organisation 2, UK)

7.2.2.2 Symptom-based Conceptualisation: Conceptualising CSA Trauma based on Presenting Conditions and Symptoms - Alleviating Symptoms and Improving Current Functioning

Another set of respondents in the UK conceptualised CSA trauma in terms of symptoms and diagnostic criteria such as post-traumatic stress symptoms or disorder, and presenting difficulties, which the child was referred for.

"But if there isn't information about the presenting concerns, we would speak to the referrer and find out because in general we would be wanting to see children who are symptomatic in this service." (Psychiatrist, CSA Specialist Service 3, UK)

The aim of the therapeutic intervention based on this conceptualisation is on improving current functioning by alleviating symptoms and better risk management, with a focus on "here and now". The need for a more structured and focussed approach or trauma models that are known to respond well to the symptoms associated with CSA was emphasised. Within this context, some reliance on an 'evidence base' and 'existing guidelines' was also pointed out, however not without some contradictions.

7.2.2.3 Developmental Stage-based Conceptualisation: Conceptualising CSA Trauma based on the Developmental Stage of the Child - Younger the Child, Greater the Difficulty in Verbalising Trauma and its Impact

Almost all professionals in the UK and India engaged in therapeutic practice recognised the difficulties experienced by younger children in comprehending and verbalising CSA-trauma experienced. All professionals reiterated that children do not sit and talk or verbalise in the same way as adults do.

> *"What actually came out from that session was that this boy* (a four year old CSA survivor) *struggled to make sense of his emotions and didn't really have the vocabulary to name his feelings of anger or sadness and would become quite kind of agitated and distressed in the sessions and start running around. A couple of times, he ran out of the room."* (Social Worker, CSA Specialist Service 3, UK)

The age of children at the time of abuse and referral for therapy had an influence on the therapeutic approach adopted by the professionals. Differences in the therapeutic approach practiced with younger and older children and/or adolescents were noted based on this conceptualisation. For example, the professionals who followed an overall symptom-based conceptualisation, difference between the therapeutic approach practiced with young children and adolescent survivors was noted based on the professionals' understanding of their (children) capacity of trauma comprehension, manifestation and expression.

To conclude, how the professionals addressed the child traumatic stress factors in terms of a therapeutic approach adopted by them was seen to be governed by the way they conceptualise CSA-trauma. These conceptualisations of CSA trauma were either influenced by the agency that the professionals were attached to, or by the professionals' own training and/or interest in a particular therapeutic school of thought. The agency or organisational conceptualisation in turn seems to be based on the understanding of the lead professional/clinician of the agency or a shared understanding of professionals associated within an agency. In case of one voluntary organisation in the UK, their understanding and conceptualisation of CSA as a 'relationship-based trauma' was informed by the research undertaken by them to develop a model of therapeutic practice for sexually abused children and young people.

Similar conceptualisations of CSA were summarised in a meta-analysis by Paolucci, Genuis, & Violato (2001). They identified two theoretical conceptualisations that explained the impact of CSA on development. One is the "core-symptom theories (p.18)", which focusses on symptomatology syndrome including PTSD and sexualised behaviour. Second, the "multifaceted models of traumatisation (p. 19)",

which is a term used for a group of theories that focus on multiple effects of CSA leading to differential outcomes. Studies suggest that mostly practitioners and researchers have applied symptom-approach to CSA by conceptualising its impact in lengthy lists of symptoms (Marrow & Smith, 1995). Other researchers report that over time, there has been a shift from symptoms based conceptualisation to greater focus on identification of constructs and core effects and developmental impact of CSA-trauma on children and adolescents (Morrow & Smith, 1995; Herman, 1992; Briere & Runtz, 1993). However, some argue that more varied impact on cognitions, body, sexuality and relationships is complicated and challenging to measure and assess (Briere & Runtz, 1993). These conceptualisations have been identified in literature to explain the impact of CSA on its survivors. The findings of the current study expand this knowledge and understanding by establishing the influence of these conceptualisations on the therapeutic interventions practiced by the practitioners in CSA-therapy with child and adolescent survivors.

7.3. CSA Trauma Resolution Framework: Key Therapeutic Approaches and Professional Challenges

Broadly, two core interrelated sets of therapeutic interventions with children and adolescents were noted: i. One-on-one trauma therapy with sexually abused children and adolescents through varied therapeutic approaches; and ii. Supportive therapy, by engaging families and larger social system, using relatively similar therapeutic practices. Professionals faced challenges in implementing these interventions for CSA-trauma resolution with children and adolescents. These challenges were associated with the growing emphasis on evidence-based practice as well as their own well-being.

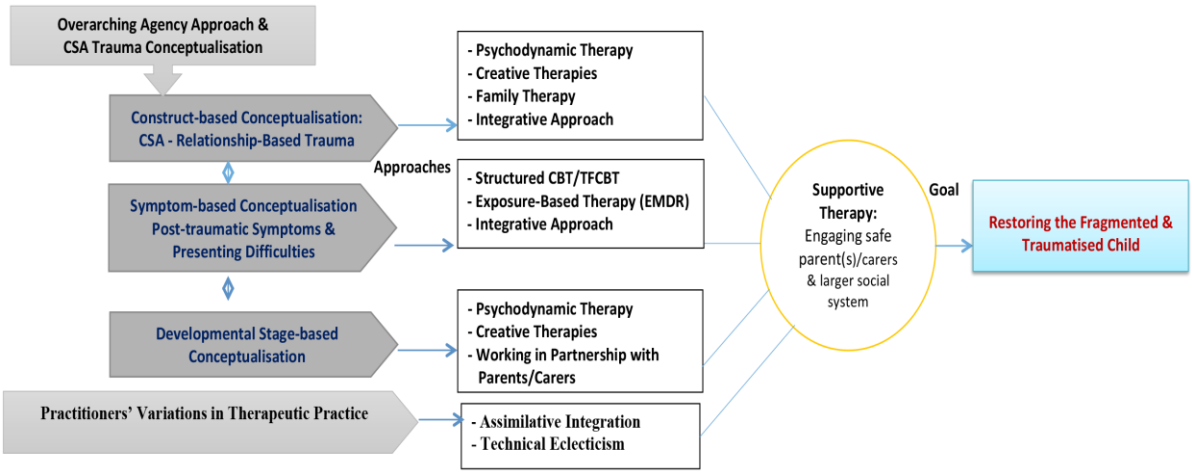

Figure 7.1: Practice of CSA-Trauma Resolution Framework

7.3.1. One-On-One Trauma Therapy with Children and Adolescents

One-on-one therapy was the main therapeutic modality practiced by all the professionals with child and adolescent survivors. With regards to the therapeutic approaches, in almost every agency selected for the study, a practice of overarching therapeutic approach at the outset was apparent based on their CSA-trauma conceptualisation largely adopted by the respective agencies. This overarching approach was stated categorically by the professionals, particularly by the first professional from a respective agency interviewed. However, on a deeper analysis of the interviews and on seeking clarifications from other professionals interviewed later from the same agencies, variations in the therapeutic approaches practiced by individual practitioners were observed. None of them seemed to practice the overarching organisational approach strictly in a purist sense, reflecting a more integrative practice by most professionals within the agencies. While most of them seemed to be guided by the principles of the overarching agency approach, their own professional orientation, training and discipline apparently influenced their individual therapeutic practice. Based on this analysis, it was inferred that while most agency adopt an overarching therapeutic approach, it remains more of a guiding framework for larger trauma understanding. Guided by this organisational framework or trauma understanding, individual practitioners within each agency

bring their own variations to the therapeutic practice. The findings also revealed a preference for long-term therapy irrespective of the trauma conceptualisation or therapeutic approach practiced. Lastly, the challenges with the evidence-base for effectiveness of various therapeutic approaches practiced, and impact of CSA-trauma resolution therapy on the professionals were also identified. These findings are discussed in detail below.

7.3.1.1 Overarching Organisational /Agency Therapeutic Choices

At the outset, practice of a core therapeutic approach with child and adolescent survivors was noted within each agency based on the CSA-trauma conceptualisation. For example, three overarching approaches were found to be practiced based on the 'relationship-based' trauma conceptualisation. These included psychodynamic approach, family therapy and integrative approach. Similarly with respect to the symptom-based conceptualisation, practice of TF-CBT was most prominent among agencies. With the developmental stage conceptualisation, the dominant practice of play and other creative therapies and/or working primarily in partnership with safe parent/carer was evident with younger children.

7.3.1.1.1 Overarching Organisational Therapeutic Approaches based on 'Relationship-based' Trauma Conceptualisation: Psychodynamic Approach, Family Therapy and Integrative Practice

While a number of professionals in the UK were observed to be informed by the 'relationship-based trauma' conceptualisation, different therapeutic approaches emerged to be in practice at the outset as agency/organisational preference to address the same, such as psychodynamic approach, family therapy and integrative practice.

Psychodynamic Therapy: Although most professionals emphasised the significance of psychodynamic principles and framework of practice, the overarching practice of psychodynamic therapy was reported by one agency. Understanding the child's inner world, psyche and unconscious processes were considered to be the core of the psychodynamic work. Consistent with the psychodynamic practice, from the

stabilisation phase onwards, professionals associated with this agency emphasised building a therapeutic relationship including establishing a sense of containment and continuity as an integral pathway for deeper trauma processing. Transference, counter-transference, and therapeutic relationship and dynamics between the child and therapist are some of the ways that helped the professionals understand and address the child's concerns and issues. It opened the doors for the therapist to take a journey into the child's inner world.

> *"I work as well with my own responses to the child, so I would also let them know about how I feel relationally with them, if I feel sad or warm or the different things that happen to me in sessions as well - use that as information to think about how... what's happening between us that may be about the child's experience, so sharing some of that with them and checking out that with them... and that might be picking up on some of their feelings that they are not able to express."* (Therapist, Voluntary Organisation 2, UK)

This involved helping the child express "inner chaos and mess" and suppressed feelings caused due to CSA and other possible traumatic episodes (such as polyvictimisation), and helping them explore and address their relationships with self and significant others.

> *"Then there is other times when the kids are so chaotic em where they can just come in the room, there is a total whirlwind and em... the things like the kind of psychodynamic principle that kind of be on stuff… the containment… that we can manage emotions and it's my job as an adult like it was the mother's job to manage the baby's emotions."* (Play Therapist, CSA Specialist Service 1, UK)

Disintegration and fragmentation of the self that happens as a result of CSA was another key area of work in therapy reported by the psychodynamic practitioners. According to the professionals, this disintegration of the self is evident in children in the ways they "dissociate" or "split-off their feelings and emotions." So being able to identify dissociation and splitting-off in children and working on their feelings and emotions was considered relevant to this work for helping children in integrating the personality and was reported as an important aspect of psychodynamic therapy.

Consistent with the psychodynamic therapeutic approach, the significance of play therapy was emphasised, although it was expanded to include various creative therapies. All therapies including play, art, crafts, drama, music, storytelling, crafts, board-games and other constructive activities were defined as creative therapies. This enabled the therapist to enter and understand the child's world including his/her suppressed feelings and experiences through symbols and stories created by the child. Consistent with the process of transference and countertransference, the emotions felt by the therapist in reaction to the child's play or "symbolism" provided an indication of the child's inner state. Similarly dreams were considered to be symbolic as well as. Hence, "symbolism" was defined by a psychodynamic practitioner as:

> *"One kind of activity that is symbolic of something different and deeper… Fairy tales are understood to be symbolic of deeper psychological process if, for example, you take a Jungian view of psychology… children's play, being very much pre-verbal or not verbal, in the kind of way that adults talk, is considered to be very symbolic."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

The significance and understanding of stories, fairy tales and symbolism manifested through creative therapies was considered essential to the trauma work within the psychodynamic therapeutic approach.

> *"This is very much where my understanding of this work involves the need to know about mythology, fairy tales, and some of the psychological ideas around the meaning of those fairy tales."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

Overall, the psychodynamic approach was considered helpful for the survivors in resolution of the trauma and reduction of stress symptoms or presenting difficulties by fostering better integration of the self and relationships with others, which became fragmented as a result of CSA and other traumatic experiences.

Family Therapy: Following the same conceptualisation of 'relationship-based trauma', family therapy was considered to be the overarching approach by another agency in the UK. This seemed to be the preferred approach due to the complex

trauma experienced by children and its impact on relationships in the family. Hence, working with families was considered to be the integral part of CSA therapy.

> *"I think our service takes a much broader view umm… and would think about the effect on parents, the effect on siblings, the effect on the relationship… and some people would argue that the relationship between the victim and the non-abusing parent has been... has had difficulties before the abuse. And certainly, maybe one could imagine after the abuse, there would be further difficulties, so we might want to do work on that."* (Psychiatrist, CSA Specialist Service 4, UK)

As the core focus of this agency was to address the dynamics within the family therapy, they did not accept referrals of stranger abuse. It primarily involved working with the individual family, which the professional emphasised often consisted of "mother and child only".

> *"The family work could be a variety of family therapy approaches… we do. And, I forgot to mention that actually, there's a…. there is a small group of families that we see where we offer theraplay… it's a well-documented but not terribly well evaluated (laughs) therapeutic approach looking at the relationship, particularly between the mother and child. And so we may offer that as well."* (Psychiatrist, CSA Specialist Service 4, UK)

Theraplay is considered to be a relationship-based, structured play therapy treatment approach for strengthening the attachment between parents and their child (Booth & Jernberg, 2009; Munns, 2000). It engages parent(s) and child together in therapy to help them relate better with each other. In different studies, theraplay has "demonstrated efficacy with various psychological and emotional problems" (Booth & Jernberg, 2009, p.85). Theraplay, besides being a relationship-based approach, also reflects the integration of creative approaches such as play therapy in the overarching practice of family therapy adopted by the agency.

Different permutations and combinations within the family therapy approach were emphasised such as working only with the family without engaging the child and/or working with the entire family including the child and siblings depending on the professional's assessment of the circumstances and needs of the child and family.

> "*Sometimes we would just see the parents, that's also not that usual, but certainly, there have been occasions where, particularly, the younger children, where they don't appear to have been as affected by what's happened but the parents have been devastated by what's happened and they want a space to think about things."* (Psychiatrist, CSA Specialist Service 4, UK)

Integrative Model of Practice: Lastly, practice of an integrative model as an overarching organisational approach was reported by three agencies in the UK and all of them in India. One of the organisations in the UK has developed an integrative, relationship-based model of practice with child and adolescent survivors of CSA. The model, titled 'Letting the Future In' was developed based on the conceptualisation of CSA as a complex and relationship-based trauma, practice experience of professionals, and research carried out by the organisation specifically for developing a therapeutic model of CSA therapy with children and adolescents.

> *"So essentially, we ended up with a relationship-based model but also rooted in the impact trauma has on the child…, in terms of defining the sexual abuse, not as a one-off event or anything, but the experience that the child had, which may be a part of a range of other experiences that may have impacted on the child*." (Therapist, Voluntary Organisation 2, UK)

Since 'Letting the Future In' model is based on Anne Bannister's, 'The Regenerative Model' (Bannister, 2003), the agency referred to it as the "Revised Regenerative Model". It consists of three linear phases including assessment, action (intervention phase), outcome and ending, and draws from different therapeutic techniques or approaches.

> *"So basically, what we're saying is we don't really use a therapy…, we draw on the techniques of these different therapies, yeah, play, cognitive, and the creative ones – drama, drumming, music... And we had hoped that… people who have been on different training courses to know which ones they want to use or which works with each child. So, I guess we call it an integrative approach, really, 'cause it does draw on a lot of different uh therapeutic techniques. So then we give a choice of a range of interventions which we think we've distilled, really, from the research*." (Therapist, Voluntary Organisation 2, UK)

While this Model proves to be an overall guide, the above extract reflects the reliance on training, skills, judgement and intuition of practitioners in application of the specific therapeutic techniques with child and adolescent survivors from among the pool of interventions suggested in the Model. This aspect seems to be a significant component of integrative practice as other agencies reinforced the same.

Emphasising the complexities and challenges involved in working on relationship issues as well as addressing the heterogeneous nature of the impact of trauma on children, professionals following an integrative approach argued that there is no one way of working therapeutically with survivors. In this regard, in-depth understanding and extensive training of professionals grounded in different theoretical foundations was reinforced.

> *"I mean our trainings are quite intense and long, for that reason it's such a complicated world of relationships. And there are lot of different theories of how to work with that… And I think that's really what this work is about, more than just painting or talking about what happened to them (*child and adolescent survivors) *with some of them much more subtle things that we need to understand and grasp theoretically and the practice you know. There is not like one way of doing this but it's the subtlety of relationships I think that's more important."* (Therapist, Voluntary Organisation 1, UK)

These integrative practitioners discussed various influences on their therapeutic work with child and adolescent survivors of CSA within the larger conceptualisation of 'relationship-based' trauma. A common emphasis was on a non-directive approach. An influence of psychodynamic approach, Bowlby's attachment theory and object-relation theory was commonly shared. From the existential psychotherapeutic base, a strong influence of humanist and person/child-centred therapy was found. The significance of "human connection" was reiterated by a number of professionals. Creative therapies were also being widely used in these agencies practicing integrative therapeutic approach. Other influences mentioned by different professionals in these agencies included Finkelhor, Gestalt, and Accommodation Syndrome by Roland Summit. Besides individual therapeutic approaches and models, family therapy or the influence of systemic working was also shared.

"Also systemic working, which is a sort of branch which most of us have got a little bit of training in or some bit of short term training, which we try and think of as much as we can because we're working with networks and looking at systems and how family systems are played out in the life of a child, the youngest generation." (Therapist, Voluntary Organisation 2, UK)

Similarly, with the aim of helping better self-integration, self-awareness, and to explore and address the relationship with self, techniques facilitating body-work and exploration of issues around sexuality were emphasised mainly using creative therapies such as dance therapy and play using toys and puppets. With the similar purpose of enhancing relationship with the self, mindfulness and meditation technique were also emphasised by some integrative practitioners.

"I use a lot of mindfulness, I use a lot of coming into the moment, I use a lot of meditation, I use a lot of coming into the body, all different things." (Therapist, Voluntary Organisation 4, UK)

To conclude, while three different approaches seem to be adopted by different agencies, a common practice observed in all agencies with a 'relationship-based' trauma conceptualisation appeared to be of creative therapies. Another commonality found in these agencies was in their assessments. The professionals in these agencies believed more in psychosocial assessment based on 'natural indicators' with limited use of psychometric tools and symptom-based inventories/instruments. Out of the responses of the professionals discussed above, only one of them mentioned the use of "under sixteen Briere trauma checklist" as part of their assessment. The rest of them relied mainly on the accounts of children, their families/carers and referrers about the difficulties experienced by children, their social environment and history. By the end of therapy, improvements observed and reported in the child became the basis of assessing the level of recovery and healing.

"I mean, the problems are so severe, in my experience, that you have natural pre- and post-therapy measures, you know, the child is soiling :: the child stopped soiling; the child can't read :: the child begins to read; the child has no friends :: the child makes some friends. The child can't sleep:: the child's beginning to sleep. These, for me, are the more natural

indicators that you can use." Clinical Psychologist 2, CSA Specialist Service 1, UK

Although the focus of the practitioners is not overtly on these presenting symptoms or difficulties, they observed that these presenting conditions that the child came with begin to subside as a result of these therapeutic interventions.

*"Yeah, well that's what happens, that the symptoms subside, we would expect that to happen, that's what we know happens." (*Therapist, Voluntary Organisation 1, UK)

7.3.1.1.2 Overarching Organisational Therapeutic Approaches based on 'Symptom-based' Trauma Conceptualisation: TF-CBT

The interventions by some agencies in the UK were found to be informed by the 'Symptom-based'' trauma conceptualisation. Based on this, the practice of TF-CBT was reported.

TF-CBT: The practice of TF-CBT as shared by these professionals involved "psychoeducation", working on "thoughts, beliefs and feelings" of children and adolescents, "visualisation" and "relaxation" techniques. Various case narratives from these professionals provided a glimpse of these strategies in their therapeutic practice aligned with the CBT approach.

"Thinking about em… her own kind of visible feelings or thoughts, what she was doing when she was feeling anxious, identifying specific triggers that might elicit that for her. I think, for example there was someone in her neighbourhood that looked similar to this man and em certain smells and things could often remind her." (Clinical Psychologist, CSA Specialist Service 2, UK)

One of the agencies reported complete adherence to TF-CBT as outlined by Cohen et al. (2006), and referred to it as "the American Manual" and their "bible" for practice.

"We draw on, an American manual by emm Cohen et al. em Trauma and Traumatic Grief that would probably be the key resource for us and they have a whole programme they run on how you do trauma focused work with this kind of group." (Psychiatrist, CSA Specialist Service 3, UK)

The focus of this therapeutic approach was to identify, assess and address the symptoms. Based on this assessment, children were provided with skills and techniques to help them deal with their presenting difficulties, in line with the CBT model. The assessment by these professionals was largely found to be based on trauma measures and scales. While one agency primarily used the Briere Trauma Symptom checklist, another agency used other instruments in addition to this checklist, such as: the Mood and Feelings questionnaire that covers broad range of emotional symptoms, the Child PTSD Symptom Scale (CPSS) for symptoms of traumatic stress, and Screen for Childhood Anxiety Related Emotional Disorders (SCARED). Besides, parent(s)/family functioning was also assessed. Respondents practicing TF-CBT and other trauma models reported the use of screening instruments routinely, pre and post therapy, for assessment of symptoms, formulation of the difficulties/problems and treatment goals, and appraise outcomes and ending of therapy.

> *"If a child is, any kind of symptoms that might indicate traumatic stress, we use the Children's Post Traumatic Scale... We use moods and feelings ... and we use em... a scale for anxiety. So we use all of those and all children coming to the service get Strengths and Difficulty Questionnaire to fill in… So we use those a lot."* (Psychiatrist, CSA Specialist Service 3, UK)

Hence, similar to the other professionals, helping children function well was the main aim of therapy. Although the parameters of 'functioning well' and the pathway to recovery of the TF-CBT-based professionals was on assessing and addressing symptoms, through scales and measures, for getting a "fuller picture" with an emphasis on "here and now".

The professionals who were found to be practicing TF-CBT asserted that their conceptualisation and associated therapeutic practice was influenced by the NICE guidelines and evidence-base. However, challenges with this assertion of the professionals were noted, discussed later in the chapter.

> *"Well as I said you would, you'd go for a more CBT approach… now you would use the NICE guidance and you would go for more sort of CBT*

approach if they've got those particular disorders." (Psychiatrist, CSA Specialist Service 3, UK)

"And it's a treatment plan, for example, we use the NICE guidelines to kind of guide us on what therapeutic treatment is kind of recommended. For example, if we see a person with post-traumatic stress disorder, the NICE guidelines suggest that trauma focused cognitive behavioural therapy works well with that particular diagnosis, so we would recommend them for that treatment." (Social Worker, CSA Specialist Service 3, UK)

To conclude, the focus of these professionals is on symptoms that the child presents with at the time of referral. Their language in the interviews also reflected this focus as they used a medical terminology emphasising symptoms, diagnosis and disorders. This was observed as being different to the terminology of other professionals with a 'relationship-based' trauma conceptualisation, where hardly any references to symptoms or disorders were made unless associated questions were raised by the researcher.

7.3.1.1.2 Overarching Organisational Therapeutic Approaches based on 'Development Stage-based' Trauma Conceptualisation: Creative Therapies and Working in Partnership with Safe Parent/Carer

Most of the discussion above, especially with regards to the structured trauma-focussed work, concentrates around the practice with older children or teenagers. Irrespective of the trauma conceptualisations and associated therapeutic practice of the agencies discussed above, consensus has been noted on the therapeutic practice with younger children amongst all professionals in India and the UK. Considering young child's lack of comprehension and ability to verbalise trauma, all agencies preferred creative therapies and/or working in partnership with safe parent(s)/main carer(s). The same was also found to be applicable for child survivors with learning disabilities, although only one therapist in the UK discussed this aspect and could not be verified further.

Creative Therapies or Creative Outlets: Similar to the 'Stabilisation and Resilience Building' phase, creative therapies or outlets were found to be practiced widely in this phase of therapy as well, particularly as the main choice of therapeutic

approach with younger children. While creative outlets were observed to be more practiced in India (and a few professionals in UK), the creative therapies were more prominent in the UK due to the training of the professionals in a combination of these therapies (for example, in case of the Clinical Psychologists) or in any one form of creative therapy such as art or play. However, creative therapies, in the UK were practiced in different ways and with different theoretical understandings/underpinnings such as psychodynamic or client-centred.

> *"Because a lot of young people aren't... they don't have the vocabulary for what's happened to them, so they don't know how to talk about the feelings they have, so the creative stuff is great for bringing in new ideas, you know, new words."* (Therapist, Voluntary Organisation 1, UK)

Creative therapies or outlets were considered to be beneficial to help children in being able to "tell their story". The same was considered to be significant for younger children as well, especially where the details of abuse or complete disclosure of it had not been made by the child. Following is an example of use of creative outlet with a four year old autistic child:

> *"I had little shadow puppets and he was constantly pressing the head down so we know something had happened to this little boy that included pressing the head down with his mouth open. He didn't know, he didn't know the name of oral sex, he had no way of telling us because he didn't know what it meant."* (Therapist, Voluntary Organisation 4, UK)

Although all agencies were found to be practicing creative therapies especially with younger children, a difference in their level of faith and acceptance of the discipline of creative therapies was noted. For some, particularly those who believed overall in the 'relationship-based' trauma conceptualisation, creative therapies seemed to be a therapy of choice with young children. These agencies had specifically trained art and/or play therapists. Even though the professionals in these agencies seemed to be aware that creative therapies lacked the evidence-base, they recognised its benefits for children in helping in trauma-expression and resolution. Further, they were found to be particular about the specifics as well including the detail of material for creative therapy and rooms/space for it. For example, one art therapist in the UK was found

to be particularly concerned about the proper space and material to be put together to facilitate play and art therapy, and spent a lot of time during the interview to show the rooms and material relevant for the practice of this approach.

> *"You probably know that there is not enough evidence base for play therapy but that's a model we often use here if it's with younger children and people when they are coming through, because that's the way we know to engage them and help them process perhaps what they have experienced. "* (Clinical Psychologist, CSA Specialist Service 2, UK)

However, on the other end, while other professionals also reported the practice of creative therapies with young children, some level of scepticism was noted in their responses. For example, a professional in the UK, primarily using TF-CBT with older children or teenagers as an overarching organisational approach, raised a concern about having to justify their practice of play therapy with younger children with respect to its effectiveness, due to the lack of an evidence-base for it. Following this reflection, two case narratives of young boys were shared with whom play therapy was used, however did not yield positive results according to the professional. Similarly, another professional in the UK with an overall structured TF-CBT therapeutic approach was critical about non-directive play therapy practice. However, creative outlets were found to be practiced by other professional interviewed from the same agency.

> *"I don't think... or things that people call play therapy, whatever that is. And I'm not sure that that's really helpful for them.*" (Psychiatrist, CSA Specialist Service 3, UK)

It can be inferred from the above examples that while the practice of creative therapies was visible in all agencies, a complete faith and training in it was lacking among some of the professionals interviewed. For some professionals in the UK and most in India, it is more use of creative outlets in absence of systematic training and skill base for the same. Further, it is presumed that some agencies adopt the practice of creative therapies perhaps due to the lack of sufficient choices for therapeutic approaches with younger children in general, and specifically with sexually abused children.

Working with Young Children in Partnership with the Safe Parent(s)/Carers: Most professionals worked with young children in partnership with their safe parent(s)/carers. The same was reiterated by the professional in India who worked with 'family-based' children. The other two professionals in India who mostly provided CSA-trauma therapy to adolescent children in a residential care home did not talk about this practice, but agreed with it in theory.

> *"So the child may, if they're able… and choose to, have some individual sessions…, with younger children, it does tend to be a bit more of a partnership with the carer."* (Therapist, Voluntary Organisation 2, UK)

> *"Em, younger than that... I'm trying to think..., quite often you would be working with the parents… often you won't work with a child that young on their own, completely on their own, I don't think. I don't think much theory would support that, but the youngest we probably had has been four."* (Therapist, Voluntary Organisation 1, UK)

Overall three variations were seen in work with younger children. One, some agencies believed in engaging young children in therapy using the medium of creative therapies. Second, a few agencies preferred working with the young child either in partnership with the parent or only with the parent. Lastly, even while working with the child therapeutically together with the main carer, some professionals used creative therapies with the child while having the safe parent/carer together in the room during therapy. On the other hand, this approach of working jointly with the safe parents/carers sounded similar, to some extent, to the supportive therapy undertaken by most professionals (section 7.3.2).

The above analysis reflects the overarching therapeutic approaches adopted by the agencies and their trauma conceptualisations. A similarity found in all agencies was that the overarching trauma conceptualisation of the agencies and associated choice of psychotherapy offered was influenced to a large extent by the interest, training and/or discipline of the lead/senior clinician or professional heading it. Junior or newer professionals (even those who were associated for approximately 2-3 years with the agency) interviewed from some of the agencies seemed unaware or

uncertain about how the organisational choice of the psychodynamic approach came about.

> "*I don't know. It would be a good question to ask Sussie (senior professional; name changed) about that because obviously she has been here longest. Em* (pause) *I assume from a kind of a perspective I think it what's, what's historically has helped the workers help the children, that's where they found some help to understand these really complex and often really confusing behaviours of children."* (Play Therapist, CSA Specialist Service 1, UK)

However, a shared understanding among different professionals in the agency about the overarching organisational perspective and therapeutic framework was apparent as a result of regular internal systematic case discussions, peer supervision and/or continued professional development (CPD). Although different professionals interviewed from same agencies accepted and conceded to the overarching conceptualisation, individual variations in the practice were emphasised.

7.3.1.2 Practitioners' Variations in Therapeutic Practice: "Practitioner's Wisdom" and "Therapist's Rucksack"

Individual practitioners within each agency did not seem to adhere strictly to the overarching organisational approach. Their experience and learning contributed to the therapeutic practice, which was referred to as "practitioner's wisdom". Since all professionals in the UK were qualified and trained in diverse therapeutic approaches, such as clinical psychologists, art or play therapists, it equipped them with the "instruments and tools" to work with therapeutically – referred to as a "therapist's rucksack" by a practitioner. Hence, variations in individual practice within each agency were noted based on the "practitioner's wisdom" and "therapist's rucksack".

> *"We are non-directive, we work psychodynamically on the unconscious processes but everybody would bring their own... everybody have their instruments in their... their rucksacks, and you would discover that meeting different clinicians."* (Art Therapist, CSA Specialist Service 1, UK)

The overarching organisational therapeutic approach is considered to be a guiding framework, rather than an approach practiced in its purist form.

> *"Well, it* (art therapy) *is my discipline and so I will just work with what I know and in what I know and similarly… a clinical nurse specialist will work that way and a psychotherapist... child psychotherapist will work that way and art psychotherapist will work... clinical psychologist... so it's within my training and approach, but the big thing is the understanding of the effects of trauma and psychodynamic kind of principle of working."* (Art Therapist, CSA Specialist Service 1, UK)

Taking the same example forward of the agency with psychodynamic therapy as an overarching organisational approach, the following excerpt by another professional from the same agency reflects the influence of other therapeutic schools or disciplines on their individual therapy practice on CSA, such as the child-centred approach in the following case.

> *"I kind of follow Virginia Axline. She has a play therapy group and she has guidelines for play therapy. And that's the kind of philosophy I guess, the guidelines if you like that I'd be using for play therapy; the kind of, em you know, it's the safe space, about accepting the child as they are, where they are. Well, I think she (Virginia Axline) emm is person-centred, maybe! Yeah, kind of person-centred, child-centred approach."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

In the same agency, one clinical psychologist worked from a Jungian/post-Jungian perspective including play therapy and concept of "symbolism", while another one quoted above followed a child-centred play therapy approach. Influences of other therapeutic approaches within the overall psychodynamic framework were found in interviews with different professionals in the same agency. These included other psychodynamic theories such as object relations theory by Wilfred Bion and other approaches including CBT, Carl Rogers' person-centred approach, and Michael Behr on Interactive Resonance.

Similarly, in another agency where the overarching approach of family therapy was reported, influences of psychodynamic and CBT approach were noted in individual therapeutic work practiced by different professionals within the same agency. This

was attributed to the interest and discipline of the practitioners associated with the agency.

> *"I* (lead clinician) *have more of an interest in family work. But most of the team have more of an inter... at the moment are interested in psychodynamic work. So we probably… steer our cases towards that sort of approach. But that doesn't mean that the people who are interested in psychodynamic work won't do a more focused CBT approach and I don't only do family therapy."* (Psychiatrist, CSA Specialist Service 4, UK)

The same was found to be true for agency with TF-CBT as their core organisational approach, as inferred from the excerpts below.

> *"So I suppose we, Emma* (lead clinician/name changed) *does more of the trauma focused work, where it's very structured and she's getting them to re-live the abuse. But we also do the more psychodynamic kind of work that I can do...Uh we've also got an art psychotherapist in the generic team and she is seeing one of our children who has been sexually abused. But she will then come to our team for consultations. Umm...so, we're kind of flexible, really, and offer a wide range of services."* (Social Worker, CSA Specialist Service 3, UK)

Similarly, a professional from the second agency that seemed to follow the practice of TF-CBT as an overarching approach referred to herself as an integrative practitioner. Further, variations in therapy with different age groups of children in the same agency were apparent, based on the 'development-stage' trauma conceptualisation. For example, a therapist from the same agency described the practice of play therapy with younger children and TF-CBT with adolescents or teenagers. This also reflects the overlap in different trauma conceptualisations within the same agency at the same time, such as symptom-based and development-stage based conceptualisation in this case. Other influences of trauma work were also found, such as the Finkelhor's traumagenic model.

> *"So I work mainly with teenagers and with some younger children as well and with the teenagers I work with em predominantly, I am using trauma focused CBT. Em… and with younger ones sometimes a bit non-directive work."* (Clinical Psychologist, CSA Specialist Service 2, UK)

In some cases, although some practitioners were found to be critical of a particular therapeutic approach, but were found to be practicing the same. For example, the lead clinician having an interest in family therapy was found to be open to the practice of CBT with severely symptomatic children even though he was critical of a PTSD diagnosis and the narrow focus of CBT.

> *"If you look up treatment in child sexual abuse, the textbooks will all have, or the literature is all about focused symptoms. So it's all about... CBT. A little bit about family therapy, but not much. I think our service takes a much broader view.* (Psychiatrist, CSA Specialist Service 4, UK)

The same was found to be true for another agency with the TF-CBT approach where primarily the practitioner was found to be critical and sceptical of non-directive approaches including play therapy, but was practicing it with younger children. Lastly, it was not necessary that all the professionals associated with the respective agency would be trained in the overarching organisational therapeutic approach adopted, and neither did the agency provided this training to the practitioners after recruiting them.

> *"There are creation elements within art therapy that are really are about unconscious processes so it* (referring to the psychodynamic approach) *wasn't too foreign but it was not specifically a training that I received."* (Art Therapist, CSA Specialist Service 1, UK)

Similar sentiments were reported by a professional from an agency with the integrative model of practice (Letting the Future In), in the excerpt below. Although a model of practice was provided by the agency to all practitioners, they expected it to be more of a guide and expected practitioners to choose specific "tools" or approaches from their own "rucksacks". This aspect was discussed earlier in the chapter and parts of the same excerpt are produced again to express the above sentiment.

> *"...people who have been on different training courses to know which ones they want to use or which works with each child. So, I guess we call it an integrative approach, really, 'cause it does draw on a lot of different uh therapeutic techniques. So then we give a choice of...a range of*

interventions which we think we've distilled, really, from the research." (Therapist, Voluntary Organisation 2, UK)

These examples suggest that the decision to apply a particular approach is left with the professional who works therapeutically with the child. It is inferred that while practitioners bring their own interest, training and skills, even the agency seems to be open to amalgamation of different therapeutic practices within a shared trauma understanding or conceptualisation perspective. The overall trauma conceptualisation and sensitivity seems to be of greater significance rather than a strict or purist adherence to a specific therapeutic approach. Further, this also reflects flexibility in practice of different professionals based on the needs, age and other circumstances of children as well as their own training and orientation. Further, it confirms that there is no one 'fixed' way of working in CSA-therapy. Professionals shared their experiences, learning and therapeutic approach practiced with others in the same agency through internal case discussions and peer supervision. It was reported to be a good way to come to a common understanding even though the exact therapeutic practice adopted by each practitioner within the same agency may be different. Hence, the overall outcomes expected from therapy for children and adolescents were reported to be similar, even though there were variations in practice.

*"Well it's essential to have like an integrated approach, so there is peer group supervision that we have every third week where we present the complex cases. Often the case holder that you share with is the person with a different background, but generally when it comes to the reports, the language is generally the same. Sometimes how you access that information be different. I access it through transference, through art work, through play, re-enactments, themes but generally the reports are pretty much… if you might be using a different word…but the outcomes are very similar" (*Art Therapist, CSA Specialist Service 1, UK)

7.3.1.3 Integrative Practice: Assimilative Integration and Technical Eclecticism

The above analysis of overall organisational approach and individual variations and preferences points towards an integrative practice with child and adolescent survivors of CSA in each agency in the UK. This orientation towards an integrative practice was acknowledged and considered significant by most of the professionals.

The professionals seemed to have the scope to practice based on their own training and discipline while following the overarching agency framework or perspective. The literature presents evidence of this kind of integration in psychotherapy, which is termed as '**assimilative integration** approach'. It "involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating or assimilating practices and views from other systems" (Jones-Smith, 2014, p. 698).

The professionals in India also confirmed the practice of an integrative therapeutic approach. However, evidence of any specific trauma conceptualisation and an overarching organisational approach was not identified. Based on their overall understanding of the child traumatic stress and social factors as well as their training and orientation, professionals seemed to follow an integrative practice. The professionals interviewed in India termed it as "eclectic practice" as they drew from various theoretical and therapeutic disciplines including EMDR, TF-CBT, psychodynamic, person-centred, traumagenic model and creative therapies/outlets. Jones-Smith (2014) refers to such a practice as '**technical eclecticism'**, defined "as an approach that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena (p. 697)."

> "*I think EMDR is definitely… which helps me to case conceptualise, my client's case but I am also reading extensively on other things like attachment, like trauma, like brain, neurobiology…, defenses emm how one can work around defenses. So that is also cognitive based you know. I am also trained in REBT, a rational emotive therapy. So uhh... it's a combination.* (Therapist, Voluntary Organisation 2, India)

EMDR was being used with older children/teenagers, not with younger children. As with the developmental stage-based conceptualisation, the professionals in India practiced creative therapies with younger children. Though one of the professionals asserted that EMDR can be used with younger children as well, however based on her training, she felt comfortable practicing it with older children or teenagers. Other approaches practiced by these professionals within the integrative or eclectic framework included TF-CBT, traumagenic model, and creative therapies/outlets.

Further, therapist's qualities of being able to establish a "human connection", judgment and intuition were considered critical by all professionals in actual therapeutic practice. It seemed that in therapy sessions, they relied on their 'therapeutic wisdom, 'rucksacks or therapeutic tools', and intuition and judgment about the 'tools' to be used. In between therapy sessions or during team discussions on respective cases and/or supervision, reflection on theoretical inputs was found to be a helpful way of being mindful of different theoretical influences or guidance on therapeutic practice.

> *"And then afterwards, you reflect on it and that's when you're really using the theories and thinking, what's happening there? What happened then? What was I feeling? What do I know about the client's history? How does what happened fit with their history? Is there something about the attachment process? Could I refer to the James Kepner model and check out where we might be on the process and see, ah, that's where we are, therefore, maybe the client needs this from me right now. How would I go about doing... that task? What are the theories I need for that task?"* (Therapist, Voluntary Organisation 4, UK)

7.3.1.4 Long-Term Duration of Therapy

Irrespective of the country context, trauma conceptualisation, and the therapeutic approach practiced, all professionals reiterated the long-term nature of CSA-trauma therapy due to the time taken from Stabilisation and Resilience Building phase onwards to the overall CSA Trauma Resolution phase.

The professionals in the agency with an overarching psychodynamic framework appreciated having a remit of longer duration of therapy for helping the child regain trust and build relationships.

> *"I think a child who's been, for example, brought up in a neglectful household, violent household and sexually abused, which many of the children I worked with had all those things, I think they need a lot of time. I think you have to be prepared to work for these children over a number of years."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

> *"I have been working for two and a half years and my first client I still see and I would think the minimum is probably around a year because of the attachment being so impaired and child is so alienated, it were that time is needed to form these relationships in order for sometimes then abuse work to take place, once that is being kind of felt like a safe place to be."* (Clinical Psychologist 1, CSA Specialist Service 1, UK)

The duration of therapy with a child usually ranged from a year to over four years. Similar views were emphasised by other professionals whether the agency adopted an overall framework of psychodynamic, family or integrative practice. None of the practitioners considered time-bound therapy with child and adolescent survivors of CSA and insisted for the agencies to have a scope for long-term work.

> *"Somehow, not having a time limit, you know, it's six sessions or two months, whatever – having the **space** to say, "This is about relationship, about noticing, about having time to build something, having time to try things and then go back to the beginning to try to learn about you. Having space to do that is important."* (Practitioner, Voluntary Organisation 1, UK)

Even those practicing more structured approaches such as TF-CBT or EMDR emphasised long-term engagement of children with the therapists due to missed sessions owing to family factors or other vulnerabilities and complexities in their life. Even though they aimed to follow eight sessions initially as per the NICE guidelines (NICE, 2005), these professionals reiterated that it usually took more time and reinforced the need for flexibility in scheduling sessions, sufficient therapeutic breaks, and overall duration of therapy.

> *"So whilst in my head it was quite clear that it was eight* (sessions) *and then we would review and plan for some more, it wasn't like eight week clear, it was kind of on and off probably over the space of four months before we got to that kind of… I had enough and done enough… and then we said let's have a break and then came back to do some more work kind of around the future."* (Clinical Psychologist, CSA Specialist Service 2, UK)

7.3.2 Supportive Therapy: Engaging Families and Larger Social System of the Child

In the UK, CSA therapy with children and adolescents can be viewed as a collaborative endeavour between the professional therapists and primary carers who are sometimes considered akin to co-therapists. It can be viewed as an extension of therapy from within the therapeutic setting where the therapists steer the therapeutic process, and the safe parent/carers as co-therapist take the therapeutic process forward outside of the therapeutic setting with support from the professional therapists.

Two key elements of supportive therapy intervention were identified: i. Enhancing support for the child through engaging families/safe carers; and ii. Enhancing support for the child by sensitising the larger social system.

7.3.2.1 Enhancing Support for the Child through Engaging Families/Safe Parent

The supportive therapy with the parents began with the 'Stabilisation and Resilience Building' phase to prepare the parents to provide adequate support and safe care to the child before initiating the trauma therapy. Within the context of the CSA-Trauma Resolution phase, the focus seemed to shift from psychoeducation on CSA and handling their distress, to actively engaging safe parent/carers as collaborators in therapy. The aim of the interventions in this phase was to enable them to adequately support the child when some of the difficulties or symptoms worsened during the trauma therapy. Although all professionals principally agreed with engaging safe parent/carer in therapy, some professionals in India and the UK were more flexible about this practice with older children/adolescents depending on the latter's comfort and choice, unless a situation of harm was observed.

> *"With the older adolescents em sometimes they don't want parents involved if they have experienced the trauma and that's very understandable so if they* (young people) *are not wanting their parents*

involved, then we have got to respect that." (Clinical Psychologist, CSA Specialist Service 2, UK)

Different procedures were practiced by professionals in the UK for engaging safe families/carers. Most professionals believed in and ensured separate therapists for working with a child and parent(s) respectively to ensure privacy and confidentiality. However, some debriefing sessions with the parent/carer and child were held together. On the other hand, a professional emphasised that parent(s) joined in for five to ten minutes with the child at the end of each session, unless the young person or teenager objected to it. Other professionals shared the practice of 'joint working' by bringing in the child and parent together in most sessions to address issues of relationships or other difficulties experienced within the family.

Psychoeducation, discussing child's concerns and progress in therapy, and imparting some practical skill training and tips on handling the child's problems or symptoms at home seemed to the main interventions with safe parent/carer.

"So, we would come together, to look at a way when a child's having a nightmare. How do you bring them back safely into the room, how to make sure that you are not just going up to them and grabbing them because that can make them feel like they are being abused all over again... So I spend quite a lot of time thinking about safe care, how you'd come into the room and you'd say their name and you'd make sure they could hear it was you (parent/carer)*."* (Therapist, Voluntary Organisation 4, UK)

Most professionals considered engaging families/safe carers as an integral component of trauma therapy for children, however emphasised that "it was not a therapy for parents". This seemed to be one of the conflicting aspects among professionals. On one hand, all professionals agreed that often parents are quite distressed, and that the sexual abuse of their child and subsequent therapy may bring up memories and issues related to their own CSA for some. As a result, they acknowledged that some parents may require therapy for their own issues beyond supportive therapy.

> *"There's often multiple often multiple stresses in the family, parents may have their own histories of abuse."* (Social Worker, CSA Specialist Service 3, UK)

However, in practice, most of them did not offer therapeutic service to parents. Parents were often referred for therapy to adult mental health services, as required, if their personal concerns and difficulties including their own CSA emerged in therapy. Being a specialist CAMHS service or voluntary organisation for CSA therapy in the UK, the therapeutic needs of children were prioritised over the personal needs and issues of parents. Their remit of providing CSA therapy primarily to children was reiterated.

> *"But if parents need therapy, they would be referred to an adult mental health service and sometimes, of course, the parents need referral to adult mental health services, so we do that*." (Psychiatrist, CSA Specialist Service 4, UK)

On the contrary, few professionals considered the above views counterproductive to the ethos of providing supportive therapy to the child. Therapy for parents including addressing their issues and difficulties was argued to be critical to enhance their ability and capacities to support to their child.

> *"The parents' ability to or their capacity to offer the child what the child needs will be informed by their own... how they were parented. And also, they may have a lot of feelings about what's happened to the child that they need to express".* (Therapist, Voluntary Organisation 1, UK)

Since the issues and difficulties of parents, especially with regards to their own abuse, often came up as an outcome of CSA of the child and/or during interaction with the therapist to address their child's abuse, these professionals asserted addressing these within their service itself. The therapeutic relationship that gets established between a parent and therapist and the stabilisation work undertaken in the first place was considered to be the catalysts for disclosures of their CSA by parents. However, inability to provide them with therapeutic support at this critical time and referring them to an external agency was considered inappropriate, not only for the parents but also from the child' perspective. The child would not receive

adequate support if parents are distressed with their own issues and difficulties. Professionals also observed that parents often did not access the adult mental health service they were referred to, which seemed to confirm their above claims. However, a gap was reiterated in this area of CSA-therapy practice.

> *"And then, if you have to refer them* (non-offending parent), *the parent feels rejected and abandoned, and quite often, doesn't turn up for the appointment that you arranged for them with an adult service."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

Similar conflict of views and practice was noted in the practice of providing therapy to siblings. Some professionals provided therapy to sibling(s) and one of them ran siblings-support groups in the past for the distress and secondary victimisation associated with CSA within the family. However, this was not practiced uniformly across agencies or services. Some only included siblings if they were also sexually abused as well and/or had witnessed it in some way, or if the sibling was one of the main carers.

> *"Interestingly, a few years ago, his* (sexually abused boy in therapy) *older sister came in to ask me to help her. And she said, 'My brother's fine, he's even got a girlfriend. He's fine but I can't do relationships… it was like she'd picked up, from when he was very young, she'd picked up a secondary abuse because she'd always been the one who spoke for him."* (Therapist, Voluntary Organisation 4, UK)

To conclude, it is evident that while the supportive therapy is an integral part of CSA-Trauma Resolution Framework, it seems to be restrictive in its scope with apparent gaps in the service.

7.3.2.2 Enhancing Support for Children and Adolescents by Sensitising the Social System

Concurrent with the therapy for the child and supportive therapy with parents, sometimes professionals engaged other service providers and stakeholders including professionals from the Universal Services (Tier 1), residential care home workers and schools. Although they were not engaged as extensively as safe parent/carer,

their involvement seemed more need-based. The interventions included trainings or one-on-one consultation, as required, in order to educate and sensitise these service providers and provide guidance if they had specific difficulties in managing a child.

Particularly for younger children, according to the professionals, working in partnership with the entire system such as the families, school and social work could bring greater benefits for the child therapeutically. The following example reflects how a therapist set up safe care for the child outside the therapy setting by working with the parents and ensuring consistency in messages to the school.

> *"And some children, when they're very frightened, physical touch, if it's safe, is a very regulating thing and I would like parents to write something* (referring to the school) *that would say, 'Don't ever touch my child unless they ask to be touched.' But if they're afraid or they need comforting, and they ask for physical warmth, you can rub their arm or you can put your arm on their shoulder, something safe, so the child can tell the difference between a positive touch and a not positive touch. So I'd be setting up things outside of the individual work as well."* (Therapist, Voluntary Organisation 4, UK)

A model of joint working by engaging different carers, especially within a residential home setting, emerged as another beneficial form of supportive intervention being tried out by an organisation in the UK. A similar model of joint or collaborative intervention was found to be practiced by a therapist in a residential home in India.

> *"The other thing that we are doing a bit more of a joint working with, in the same room, with the parent and child or a worker and young person. So that's also a bit new that we are building a model for that, really*." (Therapist, Voluntary Organisation 1, UK)

To conclude, there was a consensus amongst professionals regarding the need for and process of providing supportive therapy by engaging parent(s)/carer(s) and other stakeholders/service providers responsible for providing care to the child. However, some variations in modalities of engaging the care givers and some conflicting views were noted.

7.3.3 CSA-Trauma Resolution Interventions: Professional Challenges

CSA-trauma resolution work was considered hard and challenging for both children as well as professionals themselves. Reinforcing the limitations and contradictions in the evidence-base of different approaches for CSA therapy, having to justify their practice within the narrow framework of evidence-based practice emerged as one of the concerns of professionals. Further, working with sexually abused children and their families emotionally impacted the professionals themselves. Strategies to deal with these challenges were identified by the professionals, which are located within the overall framework of therapeutic interventions for CSA, as they enhance the competencies of practitioners to undertake and continue this work.

7.3.3.1 (Ir)Relevance of the Evidence-Base Criteria and Guidelines

The findings revealed concerns about the adherence to evidence-base practice and existing treatment guidelines. Consistent with the findings from review of literature, all professionals were aware that most of the therapeutic approaches being practiced by them, including psychodynamic therapy, family therapy, creative therapies and integrative therapy lacked the evidence-base. While they agreed that only TF-CBT has received some consensus about its effectiveness, they reiterated the limitations and contradictions associated with it. Most of the professionals, including those who practiced TF-CBT, questioned the notion of evidence-base and its restrictive assessment procedure.

> *"But I start off with the whole notion of evidence-base because evidence-base, it seems to me, to be understood in a very narrow, emm clinical psychological way or a very narrow clinical way, without a proper debate going on around about what is the nature of evidence in itself."*
> (Clinical Psychologist 2, CSA Specialist Service 2, UK)

Over-emphasis on mere "Randomised Control Trials as a gold standard"; lack of qualitative assessment of impact and outcome of therapeutic approaches, for example, review of "case studies and other clinical material"; and "lack of broader understanding of a whole range of human behaviours" in assessing the evidence-base

including social and cultural factors were among some of the reservations regarding the current stress on emphasis on evidence-based practice. Further, push towards "short term therapy because it's cheaper" based on the restrictive assessment procedures was considered to be driven by the insurance companies in the United States. Having to justify their therapeutic practice against these narrow quantitative criteria seemed to be disappointing for the professionals including those who had adopted the TF-CBT approach.

> *"I think that the biggest challenge is the evidence-base, the fact that way to justify what we do is really reduced to kind of purely evidence-base, so at times we are often challenged why are you doing this…, why are you doing that?"* (Clinical Psychologist, CSA Specialist Service 2, UK)

Limitations of the existing therapeutic guidelines and over-emphasis on TF-CBT as an accepted evidence-based approach were expressed by the professionals interviewed in the UK. This included the critique about limited relevance of the NICE guidelines that promotes the practice of TF-CBT for PTSD. The main critique was around the inappropriateness of PTSD diagnosis for children. Some professionals argued that not all children who experience CSA present with PTSD, which is consistent with the literature on PTSD and TF-CBT. The case narratives and explanations provided by the professionals using a 'symptom-based conceptualisation' and TF-CBT approach, although confirmed the referrals of severely symptomatic children with diverse symptoms and presenting difficulties, did not confirm a PTSD diagnoses in all cases of child and adolescent survivors received for therapy.

> "*My problem is that I don't agree with using PTSD, anyway, as a kind of conceptual tool for these children. Because I think PTSD comes out of trauma of one or two types... No, I'm sorry, I'm not explaining that. It's like a child has a relatively okay life and they have a trauma – like Lockerbie, where suddenly, bodies fall out of the sky… Or they have a road traffic accident or a parent is killed or murdered." (Clinical Psychologist 2, CSA Specialist Service 1, UK)*

As indicated by the professional in the above excerpt, the NICE guidance recommends TF-CBT as a preferred choice of treatment for PTSD, where it resulted

from a single traumatic event including sexual assault (NICE, 2005), referred to as Type 1 trauma in literature (Terr, 1991). Since, mostly children referred for therapy suffered with complex trauma, also referred to as Type 2 trauma (Terr, 1991), this implies that TF-CBT was being used by some professionals inappropriately with these children. Hence, the practice of TF-CBT as a therapeutic approach for complex trauma was considered inappropriate by some professionals interviewed in the UK, primarily those who practiced psychodynamic, family or integrative therapy.

> *"…when you work with a child that I'm talking about, who never had decent, basic relationships, have been brought up in families with violence, neglect, sexual abuse and a whole range of other things, then, I think, you're having to use a different model. And that's where I'm sceptical about em CBT and some of the other ones, because I think they focus on specific behaviours and they don't have a deeper understanding of the deeper psychological damage to the ability to relate." (Clinical Psychologist 2, CSA Specialist Service 1, UK)*

However, the literature review, on the other hand, reflected non-conclusive evidence for the use of TF-CBT for complex and/or single traumatic events. While some studies found it to be more effective for single traumatic events (Smith et al., 2007), others suggest its effectiveness for multiple complex trauma as well (National Child Traumatic Stress Network, 2004). This confusion is reflected in the practice and views of professionals interviewed for the study.

Hence, while there is an overemphasis on evidence-based therapies in literature and treatment guidelines, its influence on actual practice seemed limited. On the contrary, professionals were more critical of it. Similarly, consistent with the literature, critique of all approaches that were found to be practiced emerged from different professionals. It points towards the limitations of all approaches to some extent in addressing CSA-specific needs and concerns of child and adolescent survivors. For example, critique of TF-CBT by some professionals is discussed above. Similarly, some professionals were critical of non-directive therapies with child and adolescent survivors. Family therapy approach was also considered to be inappropriate for CSA trauma therapy by some. This critique was not regarding the family work i.e. in the

form of supportive therapy, however more towards a use of formal family therapy approaches.

> *"Well, we do have a family therapy service here but we don't... it's rare that sexual abuse cases are seen in the family therapy service... I think you have to be mindful of these things, the one-way mirror, videos, microphones, particularly in sexual abuse cases where that might have been a feature or there might have been issues of privacy and boundaries, it might be particularly difficult."* (Social Worker, CSA Specialist Service 3, UK)

Overall, in therapy, going beyond verbalising the trauma and merely facilitating mental or intellectual understanding of it was promoted by some professionals. It was argued that while this understanding may be beneficial, this does not help the child with trauma resolution and integration, which may lead to relapse. Hence, creative therapies including body work and mindfulness were emphasised that also do not have the evidence-base.

> *"And for a lot of therapists who are clued with the… young person who just wants to talk about it in their head, and then they don't understand why they don't feel better. We know why it happened. Often, in my experience, you have this thing where you say, 'Well I know the abuse wasn't my fault. I know why it happened. I understand the way I think about the way I think,' and it's at that moment that they try and kill themselves. Because they've got this big emptiness inside that... even though they understand it, they don't feel any better.* (Therapist, Voluntary Organisation 3, UK)

Although assessing the effectiveness or benefits of one approach over the other was beyond the scope of this study, the reservations regarding the limitations of the evidence-base and dilemmas regarding potential benefits or critique of one approach over the other are apparent from the above analysis. This is consistent with the review of existing literature and empirical studies on therapeutic approaches for CSA with child and adolescent survivors.

Having a shared understanding among professionals within each agency through ongoing case discussions in teams, peer supervisions and consultations, and ongoing professional development were identified as some of the ways of dealing with the

aforementioned challenges. These strategies within the organisations enabled the professionals to asses and formulate the therapy plans within a broader understanding or conceptualisation of trauma and needs of each child, in consultation with team members. The same strategies also helped to deal with vicarious traumatisation.

7.3.3.2 Vicarious Traumatisation: Impact of CSA-Trauma Therapy on Therapists

Another common factor relevant to CSA-trauma therapy identified through interviews with professionals was the impact of this work on the therapists themselves, referred to as vicarious traumatisation in literature. Considering the integral role of the therapist and significance of therapists' qualities, skills and competencies in this work discussed previously, this aspect of vicarious traumatisation seems relevant from the therapists' as well as therapeutic interventions perspective.

Trauma therapy proves to be as stressful for the professionals, as it is for children and adolescents. Most of the professionals with 'relationship-based' trauma conceptualisation spontaneously mentioned the stressful impact of this trauma work on them. Since most of them worked relationally towards trauma resolution by understanding the meanings attributed by children to CSA and its impact on their sense of self and worldview, they seemed to become partners in the trauma experienced by children. They seemed to immerse themselves completely in their traumatic experiences during the duration of the therapy. By working through the concepts such as building a therapeutic relationship, transference and countertransference, containment and making sense of trauma symbols through creative therapies, it is inferred that in many ways they seemed to use 'themselves' as a resource in therapy. Consequently, in order to contain the child, they themselves assumed the role of a "container" and as a result took on the impact of trauma in order to relieve the child of it. Hence, the impact of this work on their professional and personal life was apparent.

> *"It* (CSA therapy) *does provoke such strong feelings in people and you need somewhere to take that and to think about it and to process it yourself and make sense of em what's about you and what's about them. And, of course, kids, they tap in to bits of you* (therapist); *people talk about it, you have hooks and they hook in."* (Clinical Psychologist, CSA Specialist Service 1, UK)

Professional and/or personal strategies to deal with vicarious traumatisation were discussed by most professionals, primarily in the UK. Professional strategies included provisions made within the agency/organisation such as therapy for professionals by internal and/or external experts/practitioners, supervision by senior professionals as well as peer supervision, group consultations, and support from team members. At a personal level, having supportive family and friends, entertainment and relaxation activities such as socialising, meditation, and vacations were identified.

> *"To stay healthy in this work, I think we need to really... share it honestly, not just what we're doing well but share the difficult stuff with colleagues in supervision. And I honestly think being healthy, eating well and… like I do yoga but everyone's got their own thing, somehow physically being healthy is important... really important because otherwise, you know as I was saying emotionally, you can keep things inside and… we need to be healthy to do the work, but also we need to be healthy for our lives outside of work*." (Therapist, Voluntary Organisation 1, UK)

While some professionals, primarily with a 'relationship-based trauma' conceptualisation, spontaneously talked in detail about vicarious traumatisation and strategies to deal with it, it was not the case with others that followed more of a symptom-focussed structured therapeutic practice. They responded to it when asked by the researcher, and while they acknowledged the impact of this work on themselves and/or their team, strategies to deal with it were not found to be in place as much as discussed by other professionals. In fact, one professional discussed its impact on one of the new trainees rather than self when asked about vicarious traumatisation, and also recognised the lack of emphasis and strategies to deal with this within their agency.

It is speculated that in-depth engagement of the professionals with trauma per say is limited with structured trauma approaches such as TF-CBT, as the focus is more on the symptoms or presenting difficulties. This work certainly seemed to be stressful and distressing for the professionals as all of them, including those practicing TF-CBT, emphasised trauma disclosures or narratives in therapy. However, perhaps, it is more intense for those who engaged with in-depth "containment" of trauma and "hold and contain" the traumatic experiences and memories of the child in order to relieve children from these suppressed memories and emotions. This deeper engagement with CSA trauma and its integration seemed to be limited in professionals using structured approaches such as TF-CBT or EMDR as compared with the others practicing psychodynamic or other relationship-based trauma approaches. However since the topic of vicarious traumatisation was beyond the scope of the study, it was not explored at length in terms of what happens to the therapists, its impact on the therapeutic interventions practiced by them and/or overall in being able to continue this work if it was not dealt with appropriately by the agencies they were associated with.

7.4 Transition of 'CSA Trauma Resolution Phase' to the Next Phase of Therapeutic Interventions

Most often, this phase led to the next phase of intervention on 'Maintenance and Relapse Prevention', both in India and the UK. However, as discussed earlier, in some cases, a backwards movement to the previous phase for stabilisation was reported if the child did not show improvement or if severe symptoms such as self-harm were assesses. Further, at any point the therapy may stop at this level if any suspicion of harm to the child or ongoing abuse is suspected.

7.5 CSA Trauma Resolution Framework: Conclusions, Discussion and Summary

This chapter reflected upon the CSA-Trauma Resolution Framework including the therapeutic approaches practiced by the professionals and/or the agency they were

associated with as well as the factors that governed their choices, including different trauma conceptualisations.

Table 7.1: Summary - CSA-Trauma Resolution Framework

Intervention	**CSA-Trauma Resolution Therapy**
Key Therapeutic Goal	To facilitate recovery from CSA trauma by helping the survivors achieve better self-integration and revival of normalcy and optimal functioning; practiced by all professionals in the UK and a few in India.
Key Therapeutic Approaches or Interventions	• **One-on-one Therapy:** - **Relationship-based trauma conceptualisation** o *Psychodynamic Approach* o *Family Therapy/Theraplay/Family Work* o *Assimilative Integrative Approach* - **Symptom-based Conceptualisation** o *Trauma Focused Cognitive Behaviour Therapy* o *EMDR* o *Assimilative Integrative Practice* - **Developmental Stage-based Conceptualisation** o *Creative Therapies or Creative Outlets* o *Working in Partnership with Safe Parent(s)/Carer(s*) • **Supportive Therapy:** - **Engaging families/safe carers and siblings** o *Psychoeducation* o *Imparting practical skills and tips on handling child's difficulties and symptoms* - **Engaging and sensitising the larger social support system** (social workers, schools and residential care workers) o *Training and consultancy*

The findings revealed the practice of one-on-one therapy, often long-term, with child and adolescent survivors of CSA, both in India and the UK. The therapeutic practice seemed to be largely influenced by the trauma conceptualisation of the professionals and/or the agency they are associated with and/or practitioners training, orientation and experience, referred to as "practitioner's wisdom" and "therapist's rucksack". The influences of integrative practice, in the form of assimilative integration or technical eclecticism were found, even within the agencies where an overarching therapeutic approach such as a psychodynamic, family therapy or TF-CBT was adopted.

Further, a common therapeutic approach that was found to be practiced, across settings, countries as well as various conceptualisations, was the practice of creative therapies or creative outlets. While some professionals sounded sceptical about the creative therapies such as play therapy, they still adhered to this practice. In addition to one-on-one therapy with children, all professionals engaged safe parent/carer as well as the larger social support system of the child including multi-agency service providers as part of supportive therapy for the child.

Challenges and gaps in practice of these various therapeutic interventions have been discussed. The practice of different therapeutic approaches raised the dilemmas and challenges regarding the existing guidelines such as NICE in the UK, and the over-emphasis on evidence-based therapeutic practice. Most professionals were critical of it including ways in which evidence-base was defined and measured. Some of them also felt pressured to justify their practice within a narrow, quantitative evidence-base framework. It is inferred from the above reflections that there is a need for wider consultations with the professionals in the field as well as the service users (including children and families/parents) from different socio-cultural backgrounds in order to define evidence-base and consider different ways, both quantitative and qualitative, for assessing effectiveness of psychological therapies for CSA-trauma.

Overall, it is inferred from the findings that more than a specific therapeutic approach, a combination of different aspects seemed to be significant in CSA-trauma therapy. These included a sound trauma conceptualisation, training and orientation of therapists in different therapeutic approaches and theoretical underpinnings, and a peer network of therapists to share learning, experiences and complexities and seek guidance from each other. Further, the findings suggest a need for flexibility in the practice of different therapeutic approaches and duration of therapy.

With respect to the supportive therapy, the findings point towards a need for ensuring a balance between addressing the therapeutic needs of the child as well as those of the safe parent(s)/carers including siblings. A recommendation for expanding the scope or remit of the agencies in the UK emerged from some professionals in order

to accommodate therapeutic needs of parents, which would enhance their ability to support their child better. While positioning the child at the centre, it is perhaps about addressing 'the needs of the child and needs of the parents' rather than 'needs of the child vs. needs of the parents'.

Further, none of the agencies, both in India and the UK, have evaluated their therapeutic interventions practiced. Primary, scientific studies with the service users including children and young people and their families would be helpful to hear their voices about their met and unmet needs and expectations from these therapeutic services, and to understand if the current therapeutic practice is adequately informed by their needs.

Chapter Eight

Maintenance and Relapse Prevention Framework: Maintaining the Re-Integrated Child

Signposting for Future Protection and Support

"The thing I've started thinking about in the last year or so, a bit longer, is about how vulnerable they (children and young people) *might be to relapse. Because they often come from quite problematic families as well. So even though they're symptomatically and functionally better, then you risk that. So I've become interested in relapse prevention and maintenance."*

(Psychiatrist, CSA Specialist Service 3, UK)

8.1 Introduction

The last phase of the process model that has been discovered based on the findings is the 'Maintenance and Relapse Prevention Framework'. The main aim of the interventions in this phase is to help the child and adolescent survivors of CSA and their families maintain the positive changes and improvements achieved through preceding phases of the therapy, and protect them from revictimisation.

All professionals who were found to be providing therapeutic services to child and adolescent survivors of CSA, both in India and the UK, seemed to engage in this last phase of therapy although variations in the actual interventions and structural mechanisms to implement the same were found. Usually in the UK, the phases seemed to be practiced largely in a linear manner, with a few exceptions. However, in India, this last phase may be practiced soon after the first phase (Social Action) and/or second phase (Stabilisation and Resilience Building).

This chapter discusses the understanding of the professionals that drives interventions in this phase of the therapy, followed by the structural mechanisms and therapeutic interventions practiced. Figure 8.1 provides the summary of the 'Maintenance and Relapse Prevention Framework'.

8.2. Professionals' Frame of Reference: Social, Emotional and Developmental Factors

8.2.1 Social and Emotional Factors: Children's Vulnerability to Relapse and Revictimisation

The professionals discussed the emotional and social factors that make children vulnerable to revictimisation. Given the context of complex trauma and polyvictimisation experienced by most children referred for therapy, some professionals affirmed that social and environmental factors such as the family circumstances could make children vulnerable to relapse.

> *"Well, I just started to do it* (referring to maintenance and relapse prevention work) *because I just became aware that maybe just stopping, you know, when they were well, might not be good enough. Because they're, you know, they are often coming from very complex families and they're likely to have difficult issues hitting them in the future."* (Psychiatrist, CSA Specialist Service 3, UK)

The tendency of child and adolescent survivors of CSA to revictimisation was also discussed by the professionals. Due to their internal psychological and emotional factors including low self-esteem, issues of trust and difficulties with being able to form meaningful relationships, and/or due to the social situation of being in unstable or "complex families", child and adolescent survivors of CSA were perceived vulnerable to further harm including repeated sexual abuse. Literature and other research studies confirm high risk of revictimisation in survivors of sexual abuse (Messman-Moore and Long, 2000; Roodman and Clum, 2001).

> *"There's a tendency to be re-victimised because they were so dependent on other peoples' opinion of them that they would be irresistible to perpetrators who look out for vulnerable young people."* (Therapist, Voluntary Organisation 3, UK)

8.2.2 Developmental Factors: Therapy and Support Needs of Child and Adolescent Survivors at Developmental Stages of Life

All professionals interviewed conceded that children and adolescents need support at different times in life based on their trauma comprehension and impact, which is governed by their developmental stage. It is widely acknowledged in the literature and confirmed by the professionals that there are differences in the comprehension, expression and manifestation of the CSA-trauma depending on the age and associated developmental stage of the child. Hence, it was acknowledged that children may need therapy at different times in life depending on their emerging difficulties and concerns based on their developmental stage. Ergo, the therapeutic focus of the professionals seemed to shift depending on the changing developmental needs and impact of CSA on children and adolescents.

> "*People that are abused, particularly early in childhood, probably need support at different times throughout their lifetime. So, for example, it may be that at 5 years old, you might need 6 months or a year with a therapist. But then, when you get to 12 or 13 and hit puberty and sexuality comes through and you've got all the distortion of the earlier part of your life, you might need to do it* (referring to therapy) *again.*" (Clinical Psychologist 2, CSA Specialist Service 1, UK

> *"And children, you work on stuff when they're six and then I believe, for most children, they will need work again when they come into adolescence because they will understand it differently. They can only understand the abuse from the developmental stage they're at. So, six year olds understanding of abuse will be very different to a twelve-year-old and a sixteen-year-old. So they may need different things at different times."* (Therapist, Voluntary Organisation 2, UK)

Based on this understanding, signposting for possible future difficulties before ending therapy was considered critical by all professionals. A few professionals also argued for a follow-up provision within the therapeutic setting to enable children and adolescents return to therapy at an appropriate stage later in life as may be required by them. These interventions indicated by the professionals are discussed below.

8.3 Maintenance and Relapse Prevention Phase: Key Interventions

Three types of therapeutic interventions were found to be in practiced, both in India and the UK, to meet the goal of this phase of therapy: i. Short-term, immediate interventions, before terminating therapy; ii. Interim follow-up maintenance sessions; and iii. Long-term, follow-up interventions, after the therapy is terminated.

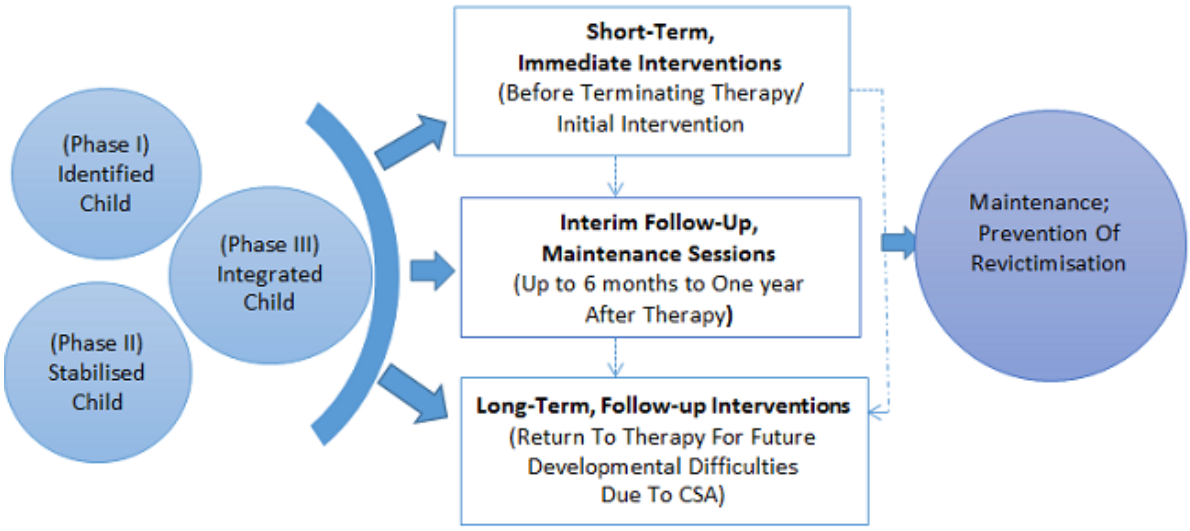

Figure 8.1: Practice of Maintenance & Relapse Prevention Framework

8.3.1 Short-term, Immediate Interventions before Terminating Therapy

These interventions were practiced by the professionals, both in India and the UK before the therapy with the child was terminated. Practice of these interventions by some NGOs in India was also visible at the end of the first phase, such as at the end of a PSE session or crisis counselling. Professionals followed one-on-one therapy modality for these interventions, and families/parent(s) of the child were usually engaged in these interventions, as with the other phases of the therapy. These interventions include:

8.3.1.1 Signposting and Preparing for Future Difficulties through Psychoeducation and Creative Outlets

Towards the end of therapy, all professionals emphasised the significance of flagging and preparing child and adolescent survivors of CSA and their families/safe parent(s) for future developmental difficulties or concerns that may come up later in life.

> *"One of the things that we know about sexual abuse, it can re-emerge as an issue for a young person at a development point or life point or whatever. So it's almost like kind of signposting or making them aware that they might need help in the future to get over a particular issue. And hopefully they'll have had a positive experience with help and will be seeking help again at that point.* (Therapist, Voluntary Organisation 2, UK)

Psychoeducation emerged as one of the key approaches practiced by all professionals to educate children and their families about possible future difficulties and developmental impact of CSA. A therapist in India also reported practice of role play as a creative outlet to provide children the practical skills for protecting themselves in future. Considering the socio-cultural factors in India where children lack agency, and most often have low self-esteem and confidence due to lack of education and lack of participation in decision-making, helping them practice assertiveness and communication skills through role play is considered to be enabling rather than just providing information through psychoeducation. A combination of both these approaches seemed to be bring greater benefits for children and adolescents.

> *"And then, with this, we again do a future role play that how can you help yourself if, suppose in future, this happens! And we terminate the session."* (Therapist, Voluntary Organisation 7, India)

Lastly with very young children, as with the other phases of therapy, the safe parent/carer was educated and prepared about the difficulties that the child may face in the future, and how can they support the child.

> "*And as the child grows, maybe at one age he will understand that whatever happened to him was not love or was not affection, was basically an abuse. And if that time, the trauma hits, what she needs to do, so preparing the mother for all of that was the major work when you*

have a child who's very small and all." (Therapist, Voluntary Organisation 7, India)

It can be inferred from the above discussion that largely professionals seemed to educate children and families about developmental difficulties that may emerge in future, however in terms of the therapeutic approach practiced, it seems to be the extension of the same approach that they follow for other two phases of therapy.

8.3.1.2 Keep Safe Work or Sexuality Education through Psychoeducation and/or Creative Outlets

Some professionals, both in India and the UK, were also found to be practicing specific approaches towards the end of the therapy to ensure child's safety from future harm and sexual abuse. For example, few professionals in the UK referred to it as 'keep safe work', while one professional in the UK and some in India considered it part of sexuality or sex education or PSE.

"Keep safe work is about talking to the children about good and bad touching, keeping themselves safe, what would they do if they felt unsafe, looking at different contexts for when somebody might touch them and getting them to think about what is appropriate and what's not and to try and prevent them from being vulnerable in the future." (Social Worker, CSA Specialist Service 3, UK)

The professionals reported following different developmentally appropriate modules such as the 'keep safe workbooks' or sexuality education or PSE modules with creative activities such as puppets, drawings, and body charts, especially with younger children, to prepare them for future safety. Some of the professionals had developed their own culturally relevant and age appropriate modules for this work, while others borrowed from pre-existing modules and workbooks such as the 'keep safe modules'.

The therapy sessions often were reported to be terminated after these sessions on ensuring future safety.

8.3.2 Interim Follow-up, Maintenance Sessions

Two professionals/agencies (one each in India and the UK) reported having follow-up sessions built-in within their therapeutic service provision itself. It means that while the therapy came to an end, these professionals made provision for a few "maintenance sessions" at regular intervals for child and adolescent survivors to come back for debriefing, follow-up or check-in. It was seen to be practiced more with older children or adolescents with their consent and willingness. No specific therapeutic approach was reported to be practiced during these follow-up sessions. These seemed more about general sharing and debriefing sessions.

> *"So with this one girl, who's done very well and she's been well now for about a year or something. What we've offered is these maintenance sessions, just every 3 months. And she used to come and see me weekly… so she just comes 3 or 4 times a year. And we just anticipate, we talk about how things have been, but also, maybe, talk through difficulties. It's just about helping her stay well."* (Psychiatrist, CSA Specialist Service 3, UK)

The same provision was made by a practitioner in India who also provided follow-up sessions to the safe parent or families if so required, with or without the child.

This provision for the interim maintenance sessions was considered to be beneficial for children and their families. One, it helped them wean-off slowly and gradually from therapy and second, considering difficulties and barriers associated with CSA disclosures, it helped them stay in touch with the same therapists with whom the therapeutic relationship and trauma history has been established. Hence, it could be considered as a cost and time-effective way of dealing with any emerging difficulties and developmental challenges associated with the impact of CSA.

> *"I think it helps, having someone you've worked with because she doesn't have to go into a long explanation about these issues, they're well known to me, so we can work at it quite quickly."* (Psychiatrist, CSA Specialist Service 3, UK)

8.3.3 Long-term, follow-up interventions, after the therapy is terminated

Although all professionals agreed that the child may need to come back for therapy, not all of them in the UK had provision for self-referrals for therapy if the child needed to come back for any emerging difficulties. Accepting self-referrals for follow up sessions as a procedure was adopted and followed consciously by a few agencies, even if they did not accept referrals first time the child came for therapy. This was done to facilitate easy and smooth return to therapy (if and when required) to the same setting and therapists where the therapeutic relationship, comfort and trauma history had been established.

> *"We wouldn't take self-referral in the first place but once they'd been with us, then, yes, they could come back to us, they could refer back to us for self-referral…. Our general principle was that if a child had had therapy with us, they could come back at any time. They might have to wait for a little, for waiting list purposes, but they could come back. They didn't need to have a re-referral."* (Clinical Psychologist 2, CSA Specialist Service 1, UK)

Some voluntary organisations in the UK also shared cases where children came back for therapy after some years as per the developmental stage and impact of CSA.

> *"We stopped the therapy after that because he'd had enough and the parents felt more confident. But he came back em about two years later because he still wasn't able to wipe his own bottom. He was still quite sensitive around bottoms and he was getting to the age where it was getting more difficult. So he came back into therapy for a while.* (Therapist, Voluntary Organisation 3, UK)

However, even though most voluntary organisations accepted self-referrals for therapy and sign-posted future difficulties, not all had the provision for undertaking follow-up work due to other practical constraints. For example, one organisation's therapeutic module that is practiced by all therapists within the organisation did not have provision for follow-up therapy work within their module.

> *"Yeah, we accept self-referrals in the beginning, so what we don't, what we haven't got provision for is for follow-up services, but obviously, if the young person wanted to come back to discuss further work or whatever,*

then emm teams would always see somebody on a one-off basis or signposting to some other kind of help. But it would be difficult, it isn't part of this guide to offer follow-up, so it would be difficult. (Therapist, Voluntary Organisation 2, UK)

In India, the above concern was not reported as most of the cases were through self-referrals, both to NGOs and other mental health hospitals and institutions.

8.4 Maintenance and Relapse Prevention Framework: Conclusions, Discussion and Summary

A strong consensus has emerged among the professionals for maintaining the positive changes and improvements achieved through therapy, and preventing relapse and revictimisation in child and adolescent survivors of CSA. There was an agreement among professionals that children may need therapy at different times in life depending on their developmental stage.

Table 8.1: Summary - Maintenance and Relapse Prevention Phase

Intervention Phase	Maintenance and Relapse Prevention
Key (Therapeutic) Goals	• To maintain the improvements and positive changes achieved through therapy/initial intervention • To prevent relapse and revictimisation of child and adolescent survivors of CSA.
Key Strategies/ Interventions	• **Short-term, immediate interventions, before terminating therapy** - Signposting and preparing for future difficulties through psychoeducation and creative outlets - Keep safe work or sexuality education through psychoeducation and/or creative outlets • **Interim Follow-up, Maintenance Sessions** • **Long-term, follow-up interventions, after the therapy is terminated**

However, the practice varied more in terms of structural mechanisms and procedures, and less with respect to the therapeutic approaches practiced. While all

professionals flagged the difficulties that may come up in future and prepared the child for the same before terminating the therapy, some also made provisions for follow-up or maintenance sessions and/or self-referrals for therapy if later required, anytime up to the age of eighteen.

Chapter Nine

The Theoretical Model: Stages and Systems of Stability

An Ecological-based Theoretical Model of Therapeutic Interventions with Child and Adolescent Survivors of CSA

The meaning of theory in any scientific field is to provide a framework within which to explain connections among the phenomena under study and to provide insights leading to the discovery of new connections.

(Tudge, Mokrova, Hatfield, & Karnik, 2009)

9.1 Introduction

The main aim of the study was to explore therapeutic interventions practiced with child and adolescent survivors of CSA in order to develop a culturally-specific theoretical model of CSA therapy. The stage-based process model of therapeutic practice followed by the professionals has been discussed in the preceding chapters based on the four principal categories developed. The therapeutic practice of professionals, in India and the UK, for CSA therapy with children and adolescents as well as the factors that govern their practice were understood based on the four conceptual categories that emerged from the data. These categories have been integrated to construct a theoretical framework of therapeutic practice with child and adolescent survivors of CSA. This chapter presents the theoretical model or framework constructed, which is grounded in the data generated from the participants and comparative analysis of relevant literature.

9.2 The Theoretical Model of CSA-Therapeutic Interventions: Systems and Stages of Stability

Although there is a growing emphasis on evidence-based therapies and most of the empirical studies focus on traditional forms of psychotherapy such as cognitive-behavioural, psychodynamic and humanist approaches, the actual practice reflects a more fluid, flexible, multi-modal and integrative approach to CSA-therapy. The definition of therapy provided by Weisz et al., (1987, p.543) seems more apt to

describe the practice of therapeutic interventions for CSA revealed from the theoretical model constructed:

> "Any intervention designed to alleviate psychological distress, reduce maladaptive behaviour, or enhance adaptive behaviour through counselling, structured or unstructured interaction, a training programme, or a predetermined treatment."

Consistent with the above definition, it was identified that professionals adopt varied therapeutic interventions in their CSA-practice, ranging from social action, non-directive approaches, unstructured creative outlets and crisis interventions to structured approaches. Furniss (1987) argues that the very framework of CSA therapeutic interventions is that the term "therapeutic" cannot be used in its traditional meaning. It is also recognised that one particular therapy may not be effective or suitable for all children (Finklehor & Berliner, 1995). This indicates a need for a more flexible approach to treatment (Lanktree & Briere, 1995), depending on the needs and cultural context of children and adolescents from different communities (Allnock & Hynes, 2012).

The theoretical model developed illustrates a broader therapeutic framework for CSA therapeutic practice with child and adolescent survivors, rather than a specific, psychotherapy approach. Therapeutic interventions for child and adolescent survivors of CSA progress through different phases and goals, based on the socio-cultural context and trauma conceptualisation of the practitioners. Socio-cultural context governs how CSA is understood and conceptualised within a particular culture, which has a significant impact on expression, manifestation and articulation of CSA experienced by child and adolescent survivors as well as on the provision of services including therapeutic interventions. Trauma conceptualisation refers to the understanding of professionals regarding the overall nature of CSA trauma and its impact on child and adolescent survivors. Trauma conceptualisation of professionals may be influenced by their training and therapeutic discipline and/or by their organisational/agency affiliations. The understanding of socio-cultural factors is also

reflected in the trauma conceptualisation of professionals as well as the influence of cultural factors on their understanding was also apparent.

Based on CSA-trauma conceptualisations of professionals and associated interventions practiced by them that were discussed in preceding chapters, the theoretical model illustrates a stage-based, multi-systems, ecological approach to therapeutic interventions for CSA with child and adolescent survivors. This theoretical model constructed resonates with the Ecological Systems Theory developed by Bronfenbrenner (1977, 1979), which explains the influences of multiple social systems that were identified in this study on the development of children. Within the framework of Process, Person, Context and Time (PPCT; Krishnan, 2010; Tudge et al., 2009), the Ecological Systems Theory emphasises the role played by the child in his/her development as well as the influence of relationships and interactions with immediate as well as other surroundings or larger social systems and environment. The Ecological Systems Theory has been utilised to explain the roots of violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), design preventive strategies on CSA (Lalor & McElvaney, 2010), examine resilience in sexually abused adolescents (Williams & Nelson-Gardell, 2012); and understand the context of CSA in cyberspace (Martin & Alaggia, 2013). It has rarely been used to inform therapeutic responses for children and adolescents affected by CSA (Lalor & McElvaney, 2010). However, on comparing the findings with the extant literature, it was evident that the CSA-trauma understanding or conceptualisations of the professionals as well as the interventions practiced by them, to a large extent, are located within the ecological, systemic framework. This makes the theoretical model constructed an original and a significant finding of this study.

A diagrammatic representation of the theoretical model constructed is provided in Figure 9.1, and the ecological framework that explains the overall CSA trauma conceptualisation of professionals as well as therapeutic interventions practiced by the professionals is discussed below.

9.2.1 Ecological Framework of CSA-Trauma Conceptualisation

The findings revealed numerous similarities among professionals, irrespective of the country, cultural and setting context, in their understanding of CSA with respect to the source of vulnerability to CSA, impact of CSA on children and adolescents including maintaining factors, as well as the core factors necessary for facilitating stability from trauma. These similarities revealed understanding of trauma of professionals within an ecological framework.

The source of CSA-trauma, or factors that made children vulnerable to CSA in the first place, was located within the context of familial and social factors since the majority of professionals identified children with complex trauma involving intrafamilial abuse, polyvictimisation and/or neglect, both in India and the UK. Risk factors were existent within majority of families prior to CSA that made them vulnerable to CSA. Further, deeply embedded socio-cultural factors of shame around issues of sex and sexuality, stigma, morality, denial of CSA and overall supremacy of adults over children increased the vulnerability of children to CSA.

Further professionals in both countries recognised and acknowledged the deep impact of CSA on child and adolescent survivors in different domains of functioning. Difficulties and presenting concerns of child and adolescent survivors were described as a combination of mental, psychological, emotional, academic, and behavioural manifestations. Overall, low self-esteem and feelings of shame, guilt, fear, and self-blame in children were reported to be common among sexually abused children, irrespective of the cultural or country context. Professionals understood that the impact of CSA was maintained or aggravated in a number of children due to the lack of safety factors and/or protective and support factors within the social system of children. Inability to disclose, being disbelieved when CSA was revealed, lack of access to therapeutic support, and threat to the safety of children in their physical and social environment were recognised as some of the consequences for children due to the lack of social support. Specific socio-cultural barriers were identified that maintained or intensified the impact of CSA on children and adolescents.

Considering the understanding of professionals about the source of trauma or vulnerability factors as well as perceptions about the overall impact of CSA on children and adolescents, the majority of the practitioners considered it critical for children to disclose and talk about trauma experienced in order to facilitate trauma resolution and restore stability in lives of children and adolescents. At the same time, working with the social system around the child was considered extremely critical to enhance support for child and adolescent survivors during therapy as well as outside of it. Therapeutic interventions for the child in isolation were not considered effective by most professionals.

Lastly, consideration of the developmental factors or developmental stage of children was also evident in the trauma conceptualisations and subsequent interventions undertaken by professionals with young children. Hence, aligned with the PPCT model of the Ecological Systems Theory, the processes focussing on the person (child and adolescents survivors), context (emphasis on the social system around the child) as well as time (developmental age and stage considerations) are reflected in the theoretical model constructed in this study based on the findings.

Hence, the theoretical model constructed espouses a developmental, ecological and systemic approach to CSA therapeutic interventions with children and adolescents. Further, this model illustrates the stage-based progression of therapeutic interventions along the continuum of CSA. This ensures addressing factors that put children and adolescents at risk to CSA and pose barriers to disclosure by perpetuating silence, as well as dealing with the impact of CSA for restoring stability by building resilience, trauma resolution and signposting for future difficulties.

9.2.2 Ecological, Stage-Based Framework of CSA-Therapeutic Interventions

The interventions to reinstate stability in the lives of child and adolescent survivors progress in stages. Due to the challenging nature of CSA-therapy as well as the socio-cultural factors that cause barriers in implementing therapeutic interventions,

difficulties in engaging children and adolescents in CSA-therapy were discussed by the professionals. Stage-based interventions facilitated taking 'one step at a time' depending on the social circumstances as well as specific needs of children as perceived by the professionals. Within each stage, interventions specific to the child as well as with the multiple systems surrounding the child were undertaken.

9.2.2.1 Stages of Interventions

The different stages of therapeutic interventions have been discussed in detail in preceding chapters, which indicated that although the therapeutic process progresses in stages, there are considerable overlaps in each stage. One stage may lead to the other while being complete in itself for providing therapeutic relief to the child and restoring stability. Interventions may progress (or not progress) from one stage to the other depending on the needs, circumstances including cultural context, and pace of children and adolescents. Hence, assessment of the child's needs is considered crucial at each stage in therapy. Further, these different stages indicated that the interventions were both retrospective (CSA experienced in the past) as well as prospective (preventing possibility of future difficulties and revictimisation) in addition to ensuring safety from any ongoing abuse or harm. Lastly, these stages also indicate that there is 'no quick fix' uniform procedure or approach to CSA therapeutic practice. On the contrary, a more long term, flexible and integrative approach to therapy was revealed.

Each stage involved a multimodal approach by engaging multiple systems. Thus, the therapeutic interventions included a combination of child-focused and supportive interventions by engaging family/non-offending parent/carer, schools, and other concerned professionals/stakeholders responsible for child protection in the larger care system.

Such stage-based approaches have been proposed by earlier researchers and trauma experts (Chu, 1992; Herman, 1992), however evaluations or effectiveness studies on these were found to be lacking.

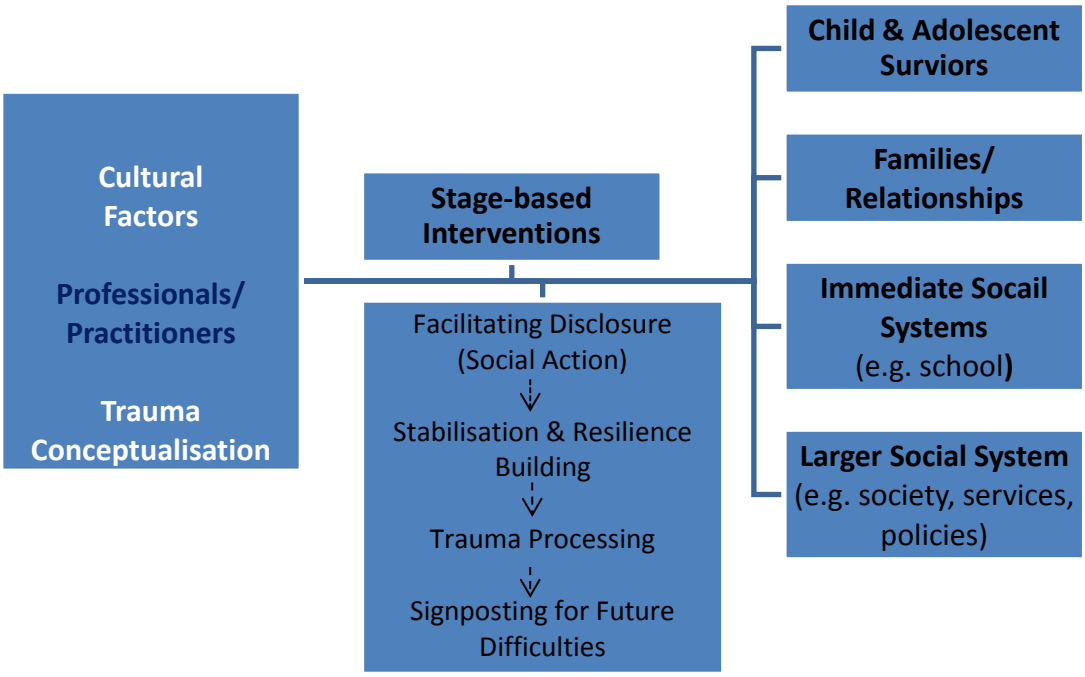

Figure 9.1: Stages and Systems of Stability

9.2.2.2 Systems

A system is defined as, "a set of units or elements standing in some consistent relationship or interactional stance with each other" (Steinglass, 1978, cited in Nichols & Everett, 1986). Working systematically ensures focusing on different units of the system, positioning the problems of individuals within a larger social framework, and providing wide range of explanations and choices for selecting interventions (Vetere & Dallos, 2003). This is also referred to as multi-modal approach, which includes a mixture of individual and family-based work, where other systems or multiple agencies of care and social support are also involved (Vetere & Dallos, 2003).

While the needs of child and adolescent survivors are central to the interventions, 'supportive therapy' is an integral component of therapeutic interventions of the

professionals in order to enhance support and stability of the child from trauma by involving the immediate family and the larger social system. Hence, within the ecological framework, the therapeutic intervention focus on the child, the family-child context, the therapist-child context; and the immediate environment and the larger social system, as demonstrated in Figure 9.2.

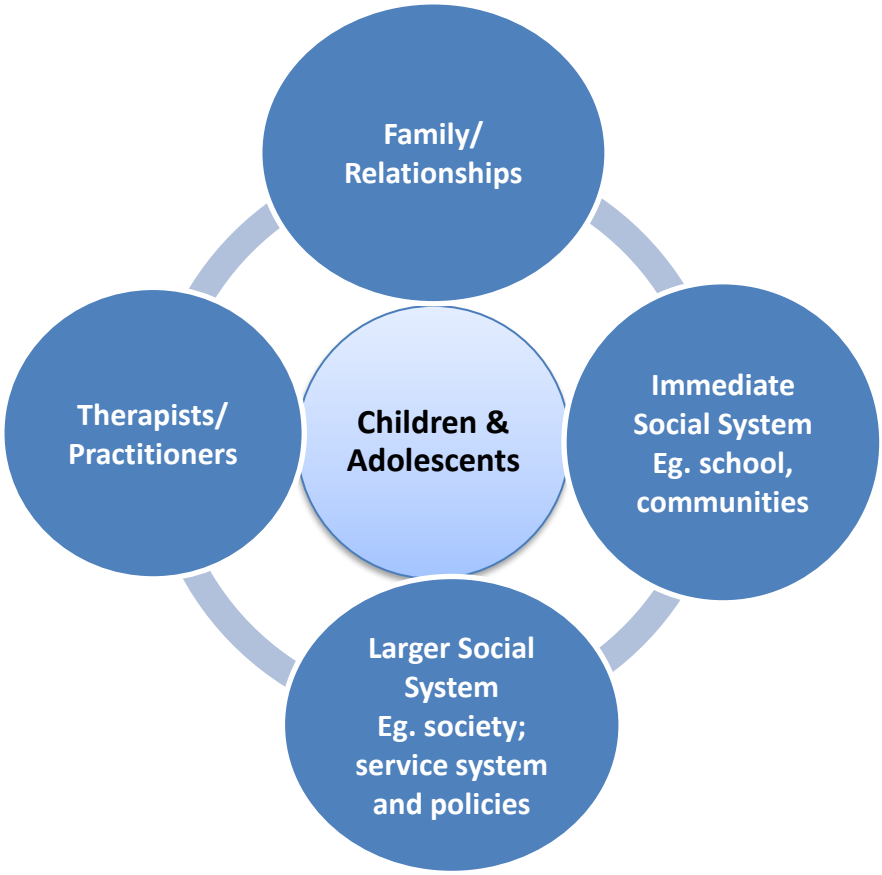

Figure 9.2: Engaging Multiple Systems in CSA Therapeutic Interventions

This systemic approach involves working with the family, specifically the non-offending parent/carer at the primary level. Further, professionals engage with schools and/or residential care institutions and peers as considered appropriate and relevant to the specific needs and circumstances of each child. Sensitising other professionals in different agencies involved with child care through consultancies and training is another integral part of the practice. Within the context of

psychotherapy, due to the significant role played by the therapist/practitioners in ensuring stability of children and adolescents from trauma, child-therapist context is also a distinct feature of CSA-therapy. It includes the significance of establishing therapeutic relationships and 'human connection'. Therefore, all these different layers of systems around the child provide a cushion of support to children and adolescents, latter being the centre of therapeutic interventions.

9.2.2.2.1 The Child-Adolescent Context of Interventions

Based on similarities observed in practice of different professionals, the theoretical model espouses key aspects or concerns considered as 'essentials' in CSA-trauma therapy with children and adolescents. All professionals addressed these aspects, irrespective of country, cultural variations or and/or the conceptualisation of the impact of CSA i.e. symptom-based or construct based conceptualisation. These include:

- Facilitating discourse of CSA and breaking the silence around it in order to aid early identification and referrals for therapeutic support.
- Securing safety including physical, social (environmental), emotional and psychological.
- Emotional and behavioural regulation.
- Building resilience by enhancing the sense of self and developing life skills, such as assertive thinking, critical thinking and other coping skill.
- Helping to form and sustain meaningful relationships.
- Trauma narratives or discussing traumatic experience(s).
- Signposting for possible future difficulties in order to prevent relapse and revictimisation.
- Consideration of developmental impact and stage of the child.
- Creating a strong supportive and protective system of relationships around the child.

The findings revealed that the therapeutic journey begins with facilitating disclosures, which itself was considered to be cathartic for the child, even though it may not be discussed in detail in the beginning of therapy. Talking about sexual abuse emerged as one of the central features of therapy, and seemed to be beneficial for children as well as professionals. It helped professionals understand and address the meanings attached to the CSA-experience by children. Facilitating disclosure has been recognised as an important part of the therapeutic process (Greenspan et al., 2013). Emphasising the significance of disclosure, it has been referred to as cathartic unburdening (Jones & Ramchandani, 1999) or cathartic release (Cahill, Llewelyn, Pearson, 1991). Deblinger et al., (2011) in a study of children aged 4-11 years found that both children and non-offending parents reported that talking about sexual abuse was the most helpful part of treatment in reducing abuse-related distress. Hence, therapies that facilitate open discussion on sexual abuse and address abuse-related issues are considered to be more effective at reducing symptomatology than therapies where the child does not/or is not required to discuss it (Cohen & Mannarino, 1996, 1997).

Further, developing resilience of child and adolescent survivors of CSA is considered to be another integral aspect of the theoretical model of therapeutic practice. This implies developing the internal resources and strengths of child and adolescent survivors as well as external protective and supportive factors within their families and immediate social environment. Considering its significance, all professionals who provided CSA-therapy, irrespective of the country, setting and/or their trauma conceptualisation, engaged sufficiently with the stage or phase of 'Stabilisation and Resilience Building'. The interventions in this stage facilitated the development of personal strengths of child and adolescent survivors through enhancing their self-esteem, self-image and survival skills, and these aspects have been considered critical in CSA therapy both by professionals in this study and researchers alike (Cahill et al., 1991; Ross & O'Carroll, 2004). In addition to the child-focussed interventions, Williams & Nelson-Gardell (2012) identified school engagement, caregiver social support, and caregiver education as important predictors of

resilience in sexually abused adolescents, which were found to be an integral part of therapeutic practice of the professionals in this study.

The theoretical model highlights the importance of the developmental needs of children, which was considered to be central to CSA therapy. However, the actual therapeutic interventions with younger children were found to be limited to creative therapies or outlets and/or largely working in partnership with non-offending parent/carer. Creative therapies and outlets were considered more relevant for younger children due to their inability to verbalise trauma experiences and/or feelings associated with it. The literature points out that the age at the time of abuse determines the extent of long-term consequences for survivors (Cook et al., 2003; Wieland, 1998; Mullen & Fleming., 1998). In addition, the links between attachment and difficulties in relationship due to CSA and the sensitivities of the developmental stage when the abuse occurs reinforces the need for working on potential relationships and attachment issues within the family (Cook et al., 2003). Hence, the engagement of the family cannot be just limited to 'supportive therapy' for the child, which came up as a major focus of work with non-offending parent/care in this study.

While some professionals in the study considered addressing symptomatology or presenting symptoms as a core aspect of therapy, others considered that the symptoms ultimately subside if the above-mentioned aspects are addressed appropriately.

9.2.2.2.2 The Family-Child Context: "Early Intervention Model"

Engaging non-offending parent/carer was regarded as an "Early Intervention Model" by the professionals. The attempt through the interventions with families or non-offending parent/carer is to build supportive and protective factors in child's family, ensure safety, and prevent long term negative consequences associated with CSA.

While the most essential aspect of therapy with non-offending parents/carers seems to be to strengthen their supportive role towards the child, other aspects of their engagement need consideration as well. For example, professionals, primarily in India, where CSA is shrouded by deep-rooted silence, conducted sensitisation workshops with families in order to increase the visibility of CSA, break the silence and consequently aid greater identification and disclosures of sexually abused children. Further, workshops on sexuality and sex education as part of CSA education were considered to address shame and stigmatisation around these issues, which become barriers to disclosure. Educative programmes for parents (and teachers) on warning signs are considered beneficial for identifying cases of CSA and reduce treatment delay (George, 2015). A parenting training component in therapy strengthens their parenting skills and practices, which lead to improvement in children's externalising behaviours (Deblinger et al., 2011).

Similarly, based on the conceptualisation of CSA as 'relational in nature', work with the family seemed critical in order to aid improving or repairing relationships that may have been affected due to CSA, or even prior to CSA, because of polyvictimisation. In this context, the influence of attachment theory (Bowlby, 1969) in conceptualising CSA as a 'relational trauma' could be beneficial, however the influence or practice of attachment-based approaches was found to be limited. The same was reflected in the literature on CSA-therapy. The focus on attachment based approaches can help understand individual processes and concerns within the context of significant relationships (Vetere & Dalos, 2003) and is proposed as a helpful conceptual framework to understand the relational aspects and consequences of CSA (Alexander, 1992). However, empirical studies on its application and effectives were not found.

The primary non-offending parent engaged in these interventions, whether through education programs or individual therapeutic work, was found to be the mother, both in India and the UK. The significant role of the mothers is also emphasised in literature on CSA therapy (Glaser, 1991). Although in some cases it was relevant as the family only included mother and the child, largely involvement of non-offending

fathers was found to be limited. By not engaging with fathers, their role in families, as well as their emotional distress and needs, are ignored (Vetere & Dallos, 2003). This also seems critical in an Indian cultural context where the mother's overall role and decision-making in the family is undermined due to the patriarchal cultural context. While engaging mothers as a first source of comfort and support for the child is significant and considered by all professionals, a gap with regards to the father's engagement needs to be noted.

Addressing parental distress associated with their personal difficulties such as history of CSA is considered another essential aspect of therapeutic intervention with family/non-offending care giver. Parental distress and psychopathology has been identified as a significant causal and maintaining factor of PTSD in sexually abused children (King et al., 1999). Consequently, broadening the scope of therapy beyond facilitating supportive role of non-offending parent/carer to also address parental distress and psychopathology (i.e., parent-focused intervention) along with child's trauma is often considered in CSA-literature (Glaser, 1991; Finkelhor and Berliner, 1995; Grosz, Kempe, & Kelly, 2000). Celano, Hazzard, Webb, & McCall (1996) found 47% of female caretakers with histories of CSA and recommended structured programmes for safe parent or caregiver so that their needs are not overlooked while working with children. Similarly, the need to involve siblings in therapeutic interventions was emphasised by some professionals in the study as it was recognised that CSA causes upheaval in the family (Duffany and Panos, 2009). The theoretical model emphasises consideration of these aspects within the scope of CSA therapeutic interventions based on the views and practice of professionals in the study as well as its significance established in literature.

Understanding perspectives of parents and care givers in therapy is considered important (Jones & Ramchandani, 1999) and effectiveness of therapy with children can often be improved by engaging non-offending parent (Allnock & Hynes, 2012).

9.2.2.2.3 Child and the Immediate Social System

This includes the social system that child interacts with outside the family such as the school, community and other peers. For example, some professionals in India undertook group work by bringing together different girls in a residential home to stabilise them by addressing shared concerns and difficulties and enhancing peer support. Most professionals also undertook training workshops to sensitise the school staff including teachers, school counsellors and principals. Another intervention included sending messages through parents to the concerned teachers and care takers at school in order to ensure consistency in the messages given to child survivors in therapy and at home, especially in the case of younger children. Similarly, all professionals in the UK undertook training and consultancy with professionals from different agencies falling in the Tier 1 (Universal services) of CAMHS, with whom the child interacts on an ongoing basis. These interventions, on one hand, ensure early identification of children with sexual abuse experiences. On the other hand, these facilitate appropriate supportive and collaborative interventions for ensuring child's well-being. Further, these interventions help in de-stigmatising CSA, thereby ensuring early reporting and preventing treatment delays. Consistent with the findings of the study, the need to establish procedures to help health care professionals identify cases for early referral has been recognised (Allnock et al., 2009).

9.2.2.2.4 Child-Therapist/Practitioner Context

Considering the critical role played by the therapist/practitioners, and the close association of children and their families with them during therapy, therapists/practitioners are being considered as a separate system from the perspective of therapeutic interventions for child and adolescent survivors of CSA. In this context, the interventions undertaken by the therapists/practitioners themselves as well as initiatives to enhance support for them and building their skills are considered to be important.

Establishing a therapeutic relationship or a 'human connection' was considered to be of prime importance in CSA therapy. This is significant in any psychotherapy, however given the relational nature of CSA trauma and issues of trust and betrayal associated with it, its significance is enhanced in CSA therapy. The therapeutic alliance developed in the beginning is considered to be the foundation of CSA-therapy. Researchers in the field of CSA-therapy have attributed improvements in children and their overall adjustment to therapeutic relationship developed irrespective of the therapeutic approach adopted (Deblinger et al., 2006). Professionals in the current study prioritised the skills and experience of therapists/practitioners in being able to establish a strong therapeutic alliance, while keeping the context of CSA and its impact on children in view. Hence, a need for a good understanding among therapists/practitioners of CSA-trauma and its impact on children and adolescents is considered critical. Investment in specific strategies and time by the therapists in building the therapeutic relationships is critical to therapeutic interventions for CSA.

With respect to interventions and role of the therapists, consideration to vicarious traumatisation may also be helpful. For example, personal and professionals strategies were considered significant for helping practitioners stay healthy and composed to enable them to continue challenging and difficult CSA work. Peer support, supervision and therapy for the therapists/practitioners were considered relevant even though not all agencies had systematic and structured practices in place to help professionals with vicarious traumatisation. A number of studies have recognised the impact of working with sexually abused children on the personal and professional life of therapists and a need for psychotherapy, supervision and other ways of coping with stress and vicarious traumatisation have been emphasised (Chouliara, Hutchison, & Karatzias, 2009; Jones & Ramchandani, 1999; Pistorius, Feinauer, Harper, Stahmann, Miller, 2008). This is considered to be "a necessity rather than merely a desirable feature of services" (Jones & Ramchandani, 1999, p. 80).

Interventions to ensure CSA-trauma education and skilled therapists were also emphasised. For example, both in India and the UK, a current need for higher numbers of trained CSA-trauma therapists was highlighted by many professionals. Integrating CSA education in curricula for mental health professionals was considered relevant in this context. In addition, while on the job training and continued professional development with the agencies were found to be useful by the professionals, they were not uniformly available to all agencies. Hence, the need for recognising CSA as a specialised field and providing CSA-specific training and continuing education to the practitioners with good supervision is reinforced based on the findings as well as its stated significance in literature by other researchers in the field (Allnock & Hynes, 2012; Czincz & Romano, 2013; Deblinger et al., 2006; Oz, 2010).

9.2.2.2.5 Larger Social System

The larger social system included the societal norms and beliefs, legal system, political system, policy makers, resources and the government. A need for a comprehensive, systemic and multi-agency response to address CSA is considered. In this context, professionals in India advocated for better services, resources, schemes and policies for the survivors due to the structural deficiencies highlighted by them. However, advocacy for specific mental health interventions and services was found to be limited, although awareness of these was noted, such as the need for community-based mental health services or a multi-disciplinary and multi-agency Comprehensive Child Protection Unit. Child advocacy centres are considered to be the ideal setting for ensuring holistic services and interventions (Grosz et al., 2000), however, a gap in this area was identified in India. Further, research on service provisions emphasise that all relevant agencies concerned with children and adolescents work together (Allnock & Hynes, 2012).

The crux of the interventions with the larger system of polices and services is to ensure early identification and reporting of CSA. By training and sensitising multi-agency professionals, early and appropriate referrals for trauma-focused treatment

are ensured. Therefore, the theoretical model developed illustrates the need for integrated, comprehensive multi-disciplinary and multi-agency interventions, by engaging all systems and agencies involved in child-serving and care giving systems (Cohen, Scheid, & Gerson, 2014).

To conclude, the theoretical model illustrates that interventions which target different systems surrounding the child are critical in restoring stability of children from the complex trauma experienced. Further, these interventions together may serve to prevent CSA as well as provide therapeutic support to survivors. Both theses aspects, of prevention and treatment, are considered critical for minimising risk of harm to children as well as the long-term consequences of CSA (Lev-Weisel, 2008; Glaser, 1991). Lastly, such a multi-system approach ensures that the interventions are embedded within the specific cultural context. Culture, here is, being defined as, "systems of shared beliefs, meanings, values, and practices." (Foucault, 1980 & Gergen, 1982, cited in Vetere & Dallos, 2003, p. 121).

9.3: Conclusions, Discussion and Summary

Reflections of the ecological framework are apparent in professionals' understanding of CSA, including the vulnerability or risk factors, impact of CSA and factors that maintain it, focus of interventions as well as the interconnections among these factors. Hence, the theoretical model emphasises the ecological framework of interventions based on the findings of the study.

This theoretical model illustrates an ecological approach to therapeutic practice for CSA survivors, targeting different systems surrounding the child. The needs, circumstances and the developmental stage of the child are largely considered to be at the centre of interventions. Further, consistent with CSA literature (Glaser, 1991), the theoretical model highlighted the practice of a more integrated, multi-modal, and a flexible approach highlighting core components of therapy rather than a uniform treatment or therapeutic approach and programme for all children. The interventions based on these core components of 'Systems and Stages' would ensure

that that they are embedded within specific socio-cultural context as well as the developmental perspective.

A number of gaps in the therapeutic practice have also been identified that provide implications for further practice and research. For example, the developmental framework of understanding and addressing trauma was emphasised by majority of the professionals. However, the interventions with young children were found to be limited to creative therapies or outlets and/or working in partnership with non-offending parent. Similarly, over emphasis on involvement of families in some instances, while ignoring the needs of children, was also recognised as another gap in interventions. The practice of rejecting the intake of children in therapy by agencies in the UK if parents were considered to be unstable or dysfunctional is one such example. However, literature on CSA treatment emphasises addressing issues relating to the abuse of the child as well as the dysfunctional relationships associated with the abuse and the child (Glaser, 1991). Similarly, another example includes the overemphasis on the well-being of families in India while ignoring the child in many cases. In such circumstances, the child is moved to the periphery with other systems such as the family and community taking up the core focus. Although working with families is important, caution is suggested in accepting parents as gate keepers of children (Allnock, et al., 2009). Hence, a good balance between family therapy and child therapy is required to ensure child's recovery from trauma while working towards improving family relationships. While positioning the child at the centre, it is perhaps about addressing 'the needs of the child and needs of the parents' rather than 'needs of the child vs. needs of the parents'. The findings revealed a gap in this area.

Based on these findings as well as the gaps identified in interventions, implications for practice, policy and further research are discussed in the next chapter.

Chapter Ten

Conclusions: The Way Forward

"I believe that the only way to attain genuine development is through our investment in the quality of life we can provide our children. This task is now the challenge of the new millennium - it cannot be accomplished by one country alone."

(Dr Zelided Alma de Ruiz, WHO, 1999, p. 4)

10.1 Introduction

The study explored CSA-therapeutic practice followed by professionals in India and the UK with child and adolescent survivors. The theoretical model constructed based on the findings illustrated a developmentally sensitive, ecological framework of CSA-therapy with children and adolescents. It emphasised intervening with child and adolescent survivors of CSA and their associated multiple-systems, as well as indicated a stage-based progression of therapeutic interventions including developmental-stage considerations. As far as I am aware, this study is the first and only of its kind to investigate therapeutic practice of professionals in different settings, especially in India, as well as examining interventions in two diverse socio-economic countries. In the UK, a study was conducted recently by NSPCC (Allnock & Hynes, 2012) at the time of conducting this doctoral study.

This chapter concludes the study with implications of the findings for policy, further research and practice as well as reflections on dissemination of the findings for knowledge exchange.

10.2 Implications for Policy, Practice and Further Research

The theoretical model or framework highlighted the need for community-based and multi-agency collaborative projects on CSA to ensure early identification as well as timely services to child and adolescent survivors of CSA. It emphasises that therapeutic services should be accessible through any available door which children

use to enter child-serving systems, such as the educational, paediatric, child welfare, juvenile justice, or mental health system (Cohen, Scheid, & Gerson, 2014). By ensuring early identification and early intervention for child and adolescent survivors, such collaborative interventions also prove to be cost effective in the long run (Cohen et al., 2014).

The similarities found in the practice of professionals as well as the gaps identified in the therapeutic practice provide implications for further practice, research, and policy.

10.2.1 Implications for Practice

10.2.1.1 Multi-System, Multi-Agency Community-based Services

A need to establish ecological, multi-system and multi-agency services has emerged as one of the core recommendations for practice. It emphasises setting up mental health services in general, and specifically for CSA-therapeutic provision, especially in India. The findings indicated lack of interface in India between the key sectors providing CSA-therapy services i.e. NGOs and hospitals. Setting up community-based multi-agency services by bringing together concerned stakeholders and systems under one roof would ensure early and timely interventions for child and adolescent survivors. There is an immense scope for setting up these services within the Child Protection Integrated Scheme of the government of India (MWCD, 2009). An example of such a Child Protection Comprehensive Unit set up by an NGO in collaboration with a mental health institution was identified in the study. Lack of government's initiative towards setting up mental health services and appropriate budget allocation for the same has also been identified. However, examples of government's initiatives and practice can be seen in India in other health care setting such as HIV prevention, care and treatment programmes where government set up a National Aids Control Organisation (http://naco.gov.in). Similar large-scale initiatives are required in the field of mental health in general, and for CSA prevention and care in India. Similarly in the UK, although such multi-agency and

multi-tier community based services, such as different tiers of CAMHS exist, their collaboration as well as CSA-trauma sensitive training of professionals in other agencies, specifically to promote early identification and support for children and adolescents with sexual abuse experiences, has emerged as a recommendation of the study.

10.2.1.2 Multi-Disciplinary and Trained Therapists

A need has emerged both in India and the UK for higher number of trained CSA-trauma therapists. While lack of financial resources emerged as a concern in both the countries, lack of quality education in the field of counselling and psychotherapy in India was also identified as a reason for lack of expert, trained counsellors/therapists in India. Training of therapists in the field of CSA-trauma, integrating CSA-trauma related education and training in educational curriculums, and ensuring measures to address vicarious traumatisation are some of the ways that could help in developing and maintaining skills and competencies of professionals.

Further, from among different stages of therapeutic interventions for CSA identified in this study, the 'Stabilisation and Resilience Building' stage was found to be practiced by most professionals in India and all of them in the UK. Some even considered this stage as a critical and beneficial stage for children, even if they do not proceed to the next stage of 'Trauma Resolution'. This stage leads to development of resources and resilience in children and adolescents by ensuring emotional and behavioural regulation and developing coping and/or life skills. In addition, this stage includes securing safety and protective factors in child's immediate environment. In this sense, this stage seems to be a beneficial 'early intervention' for child and adolescent survivors and their families. Training professionals at the very least in such a stage of interventions that seems to have universal value, even if they are not trained in practice of specific therapeutic approaches, may be helpful for bringing about stability from trauma in the lives of children.

Lastly, a forum of CSA-trauma professionals/therapist or a body governing practice may be beneficial. An example of such a forum was provided by some professionals in India. A group of practitioners coming together to discuss practice and promoting shared understanding was considered to be beneficial by these professionals. In the UK, professionals seem to draw such support from other team members in their agencies, however various agencies seemed to be working in isolation. A platform or a governing body that brings various professionals as well as survivors together to examine and review practice, research and gaps in the existing evidence-base could be a way forward to initiate and continue a discourse on this issue.

10.2.1.3 Broadening the Scope of Therapeutic Practice

The findings revealed that mostly highly symptomatic children are entering the therapeutic service system, especially in the UK as well as in the hospital settings in India. Most of them were identified as experiencing complex trauma due to the prolonged, repeated intrafamilial sexual abuse. In the process, needs of children with extrafamilial abuse or asymptomatic children seem to be ignored. It was found to be consistent with most of the empirical studies on therapeutic interventions where the focus was largely on symptomatic children, especially the ones with PTSD symptomatology. Children with intrafamilial abuse represent a distinctly different group from those abused outside the family (Lalor & McElvaney, 2010). Hence, services need to be more inclusive to identify and include asymptomatic children as well as those with other forms of sexual abuse experiences such as extrafamilial abuse and cyberspace sexual abuse (Martin & Alaggia, 2013).

Further, in some instances it was identified that the services are not completely child centric in both India and the UK. These findings echo the review of CAMHS where it was reported that children and young people did not find the services to be child-centred and felt lack of sufficient therapeutic alliance with the therapists (Davidson, 2008). Such gaps in the CSA-therapy services in all setting need to be identified to ensure that children and adolescent get the services they need and expect to ensure stability and resolution from trauma.

Lastly, a recommendation to expand the therapy services to address parental (non-offending parent) distress and psychopathology associated with their concerns such as personal histories of CSA have emerged. Similarly, the need for more family system based approaches to include different family members, such as siblings, has been identified.

10.2.2 Implications for Further Research

10.2.2.1 Testing the Theoretical Model Constructed

CGT not only helps explain practice but also provide a framework for further research through the construction of the theoretical model or guidelines that could be tested with practitioners in further research (Creswell, 2007). Though there is evidence of stage-based approaches to CSA-therapy, these have not been evaluated and lack evidence of effectiveness. The ecological-based theoretical framework of 'Systems and Stages', which includes some of the core aspects that are considered significant in CSA-therapy with children and adolescents could be tested through further research with different practitioners as well as child and adolescent survivors and their families/other systems. Further research into community-based practices in different cultural contexts may also be another way forward to identify and provide appropriate services to sexually abused children and adolescents.

10.2.2.2 Listening to Child and Adolescent Survivors

The voices of children and adolescents in therapy have not been heard. There seems to be a lack of awareness and understanding from children's perspective of what children really expect and seek from therapy, and what has benefited children who have received therapy for CSA. The findings revealed that practice is based on professionals' understanding of needs of children as well as their conceptualisation of CSA trauma, which varies amongst different professionals and agencies providing therapeutic services. There is a need for research with child and adolescent survivors

to hear their views and perspectives to strengthen therapeutic services and make them children-centric. Overall, it would ensure their participation in the services that are meant for them. The commitments, of both India and the UK, to UNCRC that emphasises child's participation as well as the IAPT programme (DH, 2011a) in the UK make such consultations with children and adolescents a necessity.

10.2.2.3 Evaluation of the CSA-Therapeutic Services by Involving the Service – Users

Further, none of the agencies in India and the UK have evaluated their services with the service-users including children and their families. Systematic audits or evaluation of services by involving the service users, and applying both quantitative and qualitative criteria would be helpful for strengthening the therapeutic services.

10.2.2.4 Redefining Evidence-Based Practice: Need for an Ecological Approach

Lastly, the study also points towards redefining the evidence-based practice including the ways of assessing it, incorporating both qualitative and quantitative methods for evaluation of effectiveness. Vetere & Dallos (2003) suggest an ecological approach to assessing evidence-base by incorporating the views, perspectives and experiences of both professionals and service-users including children, families and the larger social system. Such a centrally coordinated, ecological approach has been advocated in the prevention literature; it is recommended for the therapeutic outcome evaluation as well in order to ensure better allocation of resources and meeting the therapeutic needs of child and adolescent survivors of CSA and their families (Saunders et al., 2003)

The review of literature revealed a significant disconnect between research and actual psychotherapy practice (Czincz & Romano, 2013). Innovative research designs are required to bridge this gap. Greater research by involving practitioners from actual therapy settings can provide deeper insights into practice as found in this study.

10.2.3 Implications for Policy

Specific policies and strategies for addressing the needs of child and adolescent survivors of CSA and their families would be helpful, such as the one developed for adult survivors i.e. the National Strategy for Adult Survivors of CSA in Scotland. Considering that India has recently announced its Mental Health Policy in 2014 (Ministry of Health & Family Welfare, 2014) and the sexual assault legislation for children, POCSO 2012 is fairly recent as well, it seems timely to initiate a discourse on expanding the scope of the Mental Health Policy to include the needs of specific vulnerable populations, such as survivors of CSA.

Some of the aforementioned recommendations for practice and research can be incorporated in such a policy or strategy. Consultations with service users i.e. child and adolescent survivors of CSA, their families and other concerned stakeholders/systems for developing such a policy would be helpful to ensure that it is based on the needs of CSA-survivors.

10.3 Dissemination and Knowledge Exchange

It is considered important to share the research outcome with multiple stakeholders to contribute to the continuing development of sufficient effective therapeutic services (Allnock et al., 2009). As a commitment to the research process, I would present the summary of the findings to all the participating agencies in the study. I would continue to make presentations at different conferences and seminars. I have also offered to make a presentation on my findings at the CPG of Adult Survivors of CSA at the Scottish Parliament. It includes practitioners, academics and policy makers working on issues of CSA. I have been regularly attending the meetings of the CPG. Although the CPG focusses on adult survivors, issues relevant to child and adolescent survivors are routinely discussed.

Further, I would work towards publishing my findings in peer- reviewed journals including those that have outreach among the practitioners, such as the Child Abuse

Review and Child Abuse and Neglect as well as some of the Indian Journals such as the Indian Journal of child health and the Indian Journal of clinical Psychology. Finally, since I am interested in practical implications of the study, I intend to publish a book on my findings targeting the policy makers and practitioners.

10.4 Concluding Comments

This study is a significant contribution to knowledge about the culturally relevant, actual practice of therapeutic interventions with child and adolescent survivors of CSA in India and the UK. Based on the findings, an ecological-based theoretical model or a framework of practice for CSA-therapy with child and adolescent survivors has been constructed. In addition, the study has highlighted gaps in the current evidence-based research on therapeutic approaches to CSA with children and adolescents as well as its limitations as perceived by the professionals/practitioners. Practitioners and other researchers in the field, with whom findings have been shared so far, have found the theoretical model familiar and useful for their practice. The study concludes with practical implications for further research, practice and policy.

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Appendix 1: Information Sheet

Researcher:
Javita Narang
PhD Student
Clinical Psychology

Supervisors:
- Dr Matthias Schwannauer, Head of Clinical & Health Psychology/ Programme Director
- Dr. Ethel Quayle, Lecturer in Clinical Psychology

Information Sheet

Title of the Study: Therapeutic practice and interventions in India and the UK with sexually abused children and adolescents

Dear Mental Health Professional,

My name is Javita Narang and I am a PhD student in Clinical Psychology at the School of Health in Social Science, University of Edinburgh and part of the research group in Developmental Psychopathology and Psychological Interventions. I request your collaboration and participation in the above mentioned study. The details of the study are provided below.

The main aim of the study is to examine therapeutic practices in India and the UK with children and adolescents who have been sexually abused and explore the gaps between limited evidence-base and therapeutic practices followed in the field.

Key objectives of the study are:

- To explore the therapeutic practice(s) and interventions being followed with children and adolescents who are sexually abused;
- To investigate the factors that governs the choice of therapeutic practice(s) and interventions in different settings, such as CAMHS/CSA-Specialist Services, Mental Health Institutions, Voluntary Sector and Private Practice.

Methodology:

- Primarily qualitative study.
- Semi-structured interviews of about one hour duration with professionals in different settings.
- The place and setting of the interviews would be decided based on the convenience and availability of the participants.
- Confidentiality of the participants/respondents would be ensured at all levels: data collection, recording and transcription, data storage, reporting and dissemination.
- Findings would be shared with the participating centers/agencies.
- Participants would be requested to complete a brief information/demographic sheet at the end of the interview.

The study aims to achieve:

- Better understanding of therapeutic practice in India and the UK with children and adolescents who have been sexually abused.
- Contribute to the field of knowledge of early interventions with sexually abused children and adolescents in order to prevent long term adverse consequences.
- Construct a theoretical framework of therapeutic practice with sexually abused children and adolescents based on information gathered from research participants/respondents in different settings in UK and India.
- The report of the study is likely to be published by the end study that would be shared with the participants and their respective agencies.

Ethical approval by the Research Ethics Committee at the University of Edinburgh and NHS gas been received.

If you may require any further information or clarification regarding the study, please feel free to contact me or my supervisor, Dr. Matthias Schwannauer (contact details provided at the end of the sheet).

I request your support and collaboration for the study and hope you would be able to spare some of your valuable time for participating in the study.
Thank you for your time and consideration.

Sincerely yours,

Javita Narang

Contact Details:

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Appendix 2: Consent Form

PARTICIPANT CONSENT FORM

Title of the Study: Therapeutic Practice and Interventions in India and the UK with Sexually Abused Children and Adolescents

I, _____ am associated with _____ (name of the Centre/Agency) as _____.

I have read the attached information sheet and have clarified all doubts and queries regarding the study on 'Therapeutic practice and interventions in India and the UK with sexually abused children and adolescents' being conducted by the PhD researcher in Clinical Psychology at the School of Health and Social Science, University of Edinburgh.

I agree to take part in the study. I understand that I would be asked a range of questions in a semi-structured interview format about the therapeutic interventions practiced with sexually abused children and adolescents. I understand and agree for the interviews to be tape-recoded for the purpose of data analysis. I also understand that names of the respondents and all the information provided would be treated as confidential.

I agree that the research data gathered for the study through these interviews may be published and findings may be shared with my agency/centre.

Name of the Responded: Name of the Researcher:

Signed: Signed:

Date: Date:

Place of Interview:

Please return the signed form to Javita Narang and keep a copy for your record.

Appendix 3: Profile of Participants: India

Agency	Professional/ Designation	Qualification/ Therapy Training	No. of years in Practice
Voluntary Organisation 1	Founder Director/ Therapist	Trauma Focused Therapy, Psychodrama	15 years
Voluntary Organisation 2	Founding Director/ Counsellor	Psychology	11 years
Voluntary Organisation 3	Founding Director	No therapy training	3 years in the field of CSA
Voluntary Organisation 4	Founding Director	Not mentioned	20 years
Voluntary Organisation 4	Counsellor	No therapy training	Not revealed
Voluntary Organisation 5	Founding Director/ Counsellor	Psychosocial Model	Years in therapeutic practice: 16 Current Service: 17
Voluntary Organisation 6	Counsellor	ABT, TF-CBT, Hypnotherapy	Years in therapeutic practice: 9.6 Current Service: 1
Voluntary Organisation 7	Care Taker	Not revealed	5 years
Private Hospital 1 (Child and Adolescent Clinic)	Psychiatrist/ Psychotherapist	Not mentioned	Years in therapeutic practice: 16 Current Service: 11
Private Hospital 1	Clinical Psychologist	-	Years in therapeutic practice: 15 Current Service: 6
Private Hospital 1	Consultant Psychologist	MPhil in Clinical Psychology	2 years
Mental Health Institution 1	Child & Adolescent Psychiatrist	-	Years in therapeutic practice: 12 Current Service: 3
Mental Health Institution 2	Clinical Psychologist	Play Therapy	7 years
Independent Practitioner 1	Psychiatrist	-	15 years with 3 years in CSA therapy
Independent Practitioner 2	Psychotherapist	EMDR; psycho-analytical observational studies, trauma and group work	Years in therapeutic practice: 6-7 Current Service: 4
Independent Practitioner 3	Therapist (adolescents and young adults focus)	EMDR and counselling training	Not revealed

Appendix 4: Profile of Participants: UK

Agency	Professional/ Designation	Qualification/ Training	No. of years in Practice
CSA-Specialist Service 1	Art Therapist	Art Therapy	3 years
CSA-Specialist Service 1	Play Therapist	Play Therapy	2 years
CSA-Specialist Service 1	Clinical Psychologist 1	Doctorate in Clinical Psychology	Years in therapeutic practice: 7 Current Service: 6
CSA-Specialist Service 1	Clinical Psychologist 2	Doctorate in Clinical Psychology	Years in therapeutic practice: 15 Current Service: 8
CSA-Specialist Service 2	Clinical Psychologist 1	Doctorate in Clinical Psychology	2.5 years
CSA-Specialist Service 2	Occupational Therapist	Occupational Therapy; courses in child development	Years in therapeutic practice: 25 Current Service: 6
CSA-Specialist Service 2	Clinical Psychologist 2	Doctorate in Clinical Psychology	Years in therapeutic practice: 14
CSA-Specialist Service 3	Child Psychiatrist	-	Over 20 years
CSA-Specialist Service 3	Social Worker	Social Work/ No therapy training	2 years
CSA-Specialist Service 4	Child and Adolescent Psychiatrist	-	Over 20 years
CSA-Specialist Service 5	Consultant Psychiatrist	-	Over 25 years
Voluntary Organisation 1	Senior Practitioner and Art Therapist	Art therapy, Gestalt Therapy	8.5 years
Voluntary Organisation 2	Development Manager/ Therapist	Social Work; courses in psychotherapy	Over 20 years in current service
Voluntary Organisation 3	Psychotherapist/ Trainer/Supervisor (also practices independently)	Drama-therapy, CCPE, Transpersonal Approach	Over 20 years
Voluntary Organisation 4	Case Worker/ Young People's Project Leader	Social Work; Alternative healing	3 years
Voluntary Organisation 5	Psychotherapist	Integrative psychotherapy	Years in therapeutic practice: 14

Appendix 5: Interview Guide

Semi-Structured Interview Schedule

Duration: 1-1.5 hours

Introduction: Opening Questions

1. Could you start with telling me about your service?

2. Can you tell me about your role in the centre?

Getting the story: Questions about Therapeutic Practice

3. Can you tell me the entire process of therapy you follow, from beginning to end, when the child comes in for therapy, with a help of a case-example of a child or adolescent you may have seen?

   (Based on the case example received, probe/follow the leads or key aspects about therapy raised by the participants).

4. What informs the therapeutic process you follow? (Where do you draw from?)

- Probes:
- Ask more 'how', 'what' and when questions - (how do you do this? what does this mean?)
- Can you kindly elaborate this.....(Ask more descriptive questions that presents a picture of the 'therapy' through their responses - in the way that recreates their 'therapy practice and processes' followed').
- Give an example to explain this?
- Can you give an example from the case/client you have dealt with (prompt to share case narrative, examples and statements, incidents)
- Seek clarifications/their definitions (of concepts) when require

Closure:

5. Is there anything you would like to tell me that we have not covered?

6. Can I contact you again for any further inputs when I start analysis of the data?

Demographic sheet

Thank you and Close.

Appendix 6: Demographic Sheet

'Therapeutic Practice and Interventions in UK and India with Sexually Abused Children and Adolescents'

Agency: Date:

Interview #:

I. **A little about yourself**

Name: Sex: M/F Age:

Designation:

II. A little about your training

II.1. Have you been trained in any particular therapeutic approach/model: Yes/No

If yes, can you specify the approach/model trained in: .....

.....

II.2. Did your training focus on any specific client group/population: Yes/No

If yes, can you specify the client group/population:.....

III.A little about your work

III.1. Do you work with any specific client group/population: Yes/No

If yes, can you specify the client group/population: .....

III.2. Years in therapeutic
Service: .....

III. 3. Years in current
Service:.....

III.4. Involvement in current service: Part time/Full Time .....

Appendix 7: An Example of Line by Line Coding

Excerpts: Clinical Psychologist, CSA-Specialist Service 2	
So we are nothing to 18, all the way kind of through em but typically wee bit younger ones. Em we also work with parents first, em a kind of early intervention model working with parents - non abusing parents and then we kinda look at whether the young people are very em you know much younger to be seen and we kind of limit to happen as well and see them for individual work.	Defining age group/focus of the service; working more with younger children Eengaging non-abusive parents initially Working with parents first considered as early intervention model Practicing individual work; seeing children for individual therapy
Em..and with younger ones sometimes a bit non-directive work. Then about psycho-education around safety, giving them a space to actually think about what they have experienced and help them em managing those difficult feelings or some of those thoughts what's their in for them.	Practicing non-directive work with younger children Psychoeducation around safety ensuring safety of children Creating safe space for children helping children reflect upon their experience (of sexual abuse) Addressing and helping children in managing difficult feelings and thoughts
So for young people often they are around to blame you know, I should have that or I should have just stopped this. I am feeling responsible, it's my fault, I could have , I should have, those kind of thoughts are right through them that often drive their movement and drives you know what's gonna come through their presentation. So I work with them to help them to see how those beliefs and thoughts are kind of errors and I am trying to give them techniques and strategies to challenge those kind of beliefs and thoughts	Identifying Feelings of guilt and self-blame in children Children presenting with feelings of self-blame and guilt in therapy Recognising and addressing errors in beliefs and thoughts Providing 'techniques and strategies' for challenging faulty beliefs and thoughts
Excerpts: Clinical Psychologist, CSA-Specialist Service 2	
So, I think it's really important to introduce a client to space, to me. I encourage my child to ask lots of questions. so a young person who comes in and meets with us quite informally first and I also will tell them they, all would have been referred cos they have been	Making children comfortable Ensuring openness and transparency Creating informal space Ensuring openness and transparency

part of the referral, so they know why they are coming, they should know why they are coming… Ya, they should...they have usually filled in the part of the referral form which says - we help em..young people who have been sexually abused, how do you think we can help you? So they should...and we encourage refers to make sure that the child is aware of that because then the child has more power, to say ya..this is why what happened or I don't wanna talk about it or whatever...	Assessing children's needs/expectations from therapy Equalising relationships between therapist and child Making children feel in control and powerful
Em we used to do groups for a start, em there was groups, there had been groups and it's not really a deliberate decision not to offer it em we trying to offer a group few years ago; and it's a funny thing because to start a group you need to have referrals who are appropriate for a group but to get those referrals you have to advertise that you are doing a group...so its a bit of development work I suppose for the team to do and it just hasn't that has been something that's been obvious this is needed if it had been a thing, we would have responded to that. Em..I think that the groups can work really well for young people who have been sexually abuse, it just hasn't happened for us that that's been an obvious way to go again..	Practiced group work in the past Practical challenges in organising group work Responding to emerging needs Lack of need/demand for group work
Excerpts: Clinical Psychologist, Mental Health Institution, India	
In private setting, you hardly get it (CSA cases), say example, a few months ago we had a case. It was referred for conduct disorder and when we were looking into it like you know, like a lot of for an adolescent looking into em in dealing with a lot of other emotional issues and all that. When we were going through exploration stage and that's where it was emerged that she has been repeatedly been molested as a child… and then in further enquiry then we realised that even the second daughter is also going through the same experiences and all that . So that is how it was, it is picked up…	Rare cases of direct CSA received Referrals for behavioural and emotional difficulties (not CSA) Disclosures of CSA during therapy for other presenting problems ('secondary issues')

… With younger children, we sometimes use in exploration stage sometimes play therapy you know, various mediums basically that the verbally they are not able to....then drawing or play whatever they feel comfortable.	Engaging younger children through play for assessing CSA Non-verbal expression of children/challenges in expressing verbally Responding to child's need and comfort

Appendix 8: An Example of Development of a Conceptual Category

Stabilising Children and Adolescents: Line by Line Coding to Focussed Coding, and to Conceptual Category

Excerpts from Transcripts	Line by Line Coding	Focused Codes	Conceptual Category	
"What's happening at home? May be they are safe from abuse?" (Clinical Psychologist 1, CSA-Specialist Service 1, UK)	Concern about safety from abuse	**Assessing and Ensuring Physical Safety**	**Assessing and Ensuring External Safety**	
"Children need to be safe from further abuse, the abuse needs to be investigated so the relevant authorities need to know about it." (Play Therapist, CSA-Specialist Service 1, UK)	Concern about safety from abuse; Reporting harm			
"That if the child is all over the place, because they don't know where they're sleeping next week, for example, they may be in a refuge with their parents or they may be uh being looked after in a temporary accommodation." (Therapist, Voluntary Organisation 2, UK)	Assessing physical living conditions and stability			
"Any people the child could identify who probably are not people with a very comfortable ambience for the child, they need to be told to the trustworthy next of kin." (Psychiatrist, Hospital 3, India)	Ensuring safety in physical environment; Reporting child's discomfort with surrounding people			
"Sometimes what happens if the intrafamilal abuse becomes very complex because if the alleged offender is one of the other family members such as a parent or grandparent or uncle or something is in the same environment." (Psychiatrist 2,	Abuser being in the same environment; Compromising child's safety			

Hospital, India)			**and Stability**	
"We cannot let the abuse go on. The therapy is at one level, but if there is abuse, you have to do something." (Therapist, Voluntary Organisation 7, India)	Stopping ongoing abuse is a priority; taking action to stop abuse			
"What I'd be most concerned about is… the way they're living now – is it as positive as possible? It's normative and it's pro-social." (Psychiatrist, CSA-Specialist Service 5, UK))	Concerned about safety in social environment	**Ensuring Social Safety/ Safe, Supportive, Social Environment**		**Stabilising Children and Adolescents:** Prerequisite of CSA Therapy with Children and Adolescents
"So we decided I would go in and work with the child, but to begin with, we set up some safeguards. So in the school, we wrote an intimate care plan." (Therapist, Voluntary Organisation 3, UK)	Ensuring safety within immediate social system			
"If they are (parents) not willing to come and do that, then it might be that we wouldn't feel that it was a good time for the child to be coming along." (Clinical Psychologist 1, CSA-Specialist Service 1, UK)	Assessing parental support for intake of child in therapy			
"I think there are some situations when it's really… almost dangerous to do therapy with a child if they're in a very unstable situation and people can't support the child." (Clinical Psychologist 2, CSA-Specialist Service 1, UK)	Unstable and unsupportive environment dangerous for therapy			
"I think the first and foremost initiative has to be to provide a complete, safe, secure, supportive environment from the point of discovery." (Psychiatrist, Hospital 3, India	Intervening to ensure safe and stable social environment			
The feelings are too overwhelming to even begin to manage so we need to work on managing those feelings first before they can be here (in therapy) (Rona)	Managing and normalising feelings before engaging in therapy	**Ensuring Emotional**	**Assessing and Ensuring Internal Safety**	
"Sometimes you have to kind of do that for the child 'cos they	Assessing emotional safety			

present so anxiously and the child can't actually say and sometimes we say at the end of the assessment period, actually this is too much for your child.., they are not going to manage it." (Psychiatrist, CSA Specialist Service 3, UK)	for intake of child in therapy	**Safety and Stability**	**and Stability**	
"Em there are also issues around, in terms of, is it safe for this child to be in therapy at the moment, is it emotionally safe?" (Clinical Psychologist 1, CSA-Specialist Service 1, UK)	Assessing emotional safety			
"*So unless they know how to deal with their uhh.. they were able to soothe themselves, able to take care of their you know emotions, if I go straight back to traumatic memories it will be extremely overwhelming."* (Independent trauma therapist, India)	Facilitating emotional regulation/ emotional stability			

Appendix 9: Mapping Exercise

Appendix 10: Memo - Sexually Inappropriate Behaviour (Initial Thoughts)

Most agencies in the UK have built in programmes for sexually inappropriate behaviour, but some have different sections/teams working with children who are referred for sexually inappropriate behaviour and sexual assault respectively. So when they get a referral of a child who is displaying some kind of a sexually inappropriate behaviour, that goes to a separate team whereas the sexual abuse referral would go to member of another team that specifically provides therapy for CSA. Sometimes they do see the linkage between CSA and sexually inappropriate behaviour; and sometimes they don't. It was expressed that sexually inappropriate behaviour may not always be linked to CSA. Most agencies keep these as separate issues and they don't really bring them together.

When I began, I didn't see these differences which are coming up very clearly. I need to see if I should address these as one issue and explore interventions for them together or keep them separate. A professional indicated that these are separate issues, with both requiring different therapeutic inputs and interventions. She suggested planning a similar but separate study for sexually inappropriate behaviour as well rather than mixing the two together. So it might not really be good to mix the two and perhaps keep these two separate. I think maybe I should not bring in sexually inappropriate behaviour, unless there are linkages that come up from the professionals? This is an area that I need to think about and discuss with my supervisor and see what comes up in other interviews.

Appendix 11: Memo: Identifying Relationships

Identifying relationships between and among different categories and reflecting upon different phases in therapy

Identifying the silenced and invisible child

Properties: Child - Invisible and hidden child?

The starting point for professional interventions with sexually abused children is based on the core question, 'Where is the Child?' i.e. where are the children who have been sexually abused? Based on this focus, the interventions start with primarily 'identifying the silenced and invisible child' by addressing the factors that make these children invisible and breaking the silence. This first level of interventions for breaking the silence has been reported primarily by the professionals in India.

Silenced Child: Professionals reported that there are a large number of children who are invisible and hidden in silence due to barriers to disclosure faced by them. Majority of sexually abused children do not reach up to the therapeutic services or are unable to access these services. Even the existing prevalence and incidence data indicates that CSA is underreported both in India and UK. This implies that there are a large number of children in both these countries who are invisible or are hidden in silence, without reporting CSA themselves or being identified by the relevant authorities including legal, social care or the mental health professionals. Different factors/properties indicating the extent of silent suffering experienced by children is reported by professionals, primarily by NGOs in India. There are universal factors of force, threat, coercion or grooming that become barriers to disclose for children where the children are threatened and/or groomed into CSA and accordingly pressurised to stay silent. However the focus of this intervention of identifying silenced children is based on the understanding of the professionals of the socio-cultural factors in India that push children into silence. Hence, the interventions largely are designed and implemented to address these socio-cultural barriers for 'identifying the silenced and invisible child' and 'breaking the silence'.

Scope of interventions: The interventions for identifying these invisible children have been reported by all NGO professionals in India through social action framework. It is considered a prerequisite for engaging sexually abused children in therapy. However, this sharp focus on social action has not come up in responses of professionals from hospitals in India as well as the agencies in the UK (even within the ethnic minority organisations). This variation in findings possibly could be due to the differences in the nature of services. The focus and remit of the agencies in the UK and hospitals and institutions in India is primarily therapeutic. These agencies offer direct therapeutic services to sexually abused children and adolescents as well as their families/carers and immediate social system to enhance support for care

and support for children and adolescents undergoing therapy. The agencies in the UK only accept referrals for therapy when CSA has been disclosed, reported and investigated. Similarly, the focus of mental health professionals in hospitals and institutions in India is primarily mental health care. They are not set up as the CSA specialist agencies or departments however provide care to children and adolescents as part of their wider mental health services. These children and adolescents could be accepted for specific CSA therapy (which is rare) and more often for behavioural, emotional, psychological or academic difficulties experienced by children. Hence, they do not work beyond the scope of the therapeutic interventions to sexually abused children. Similarly, the focus of ethnic minority organisations seem to be on empowering children and young people addressing identity and self-worth issues so that they can open up and disclose if they experience CSA.
The findings indicate that all NGO professionals work towards addressing the factors that push children in silence.

Grounding the apprehensive child – the pre-requisite for challenging trauma work
Introduction (Key Properties)- Grounding the child:

At this stage, key question that the professionals are assessing and addressing with regards to the core category of 'Where is the Child?' is that where is the child located in terms of the stability and security before and during initiation of therapy. For them, this lays the foundation for engaging the child in therapy in the first place and influences the therapeutic interventions during the initial phase of the therapy.
This initial phase of assessment and intervention is considered highly significant by the professionals both in India and UK for two key reasons. One, all professionals interviewed, irrespective of the country and setting, hold that therapy for CSA trauma is highly challenging and difficult for children and adolescents (and for therapists as well). Second, it is shared by the professionals that children are quite apprehensive when they are referred and initially come for therapy.

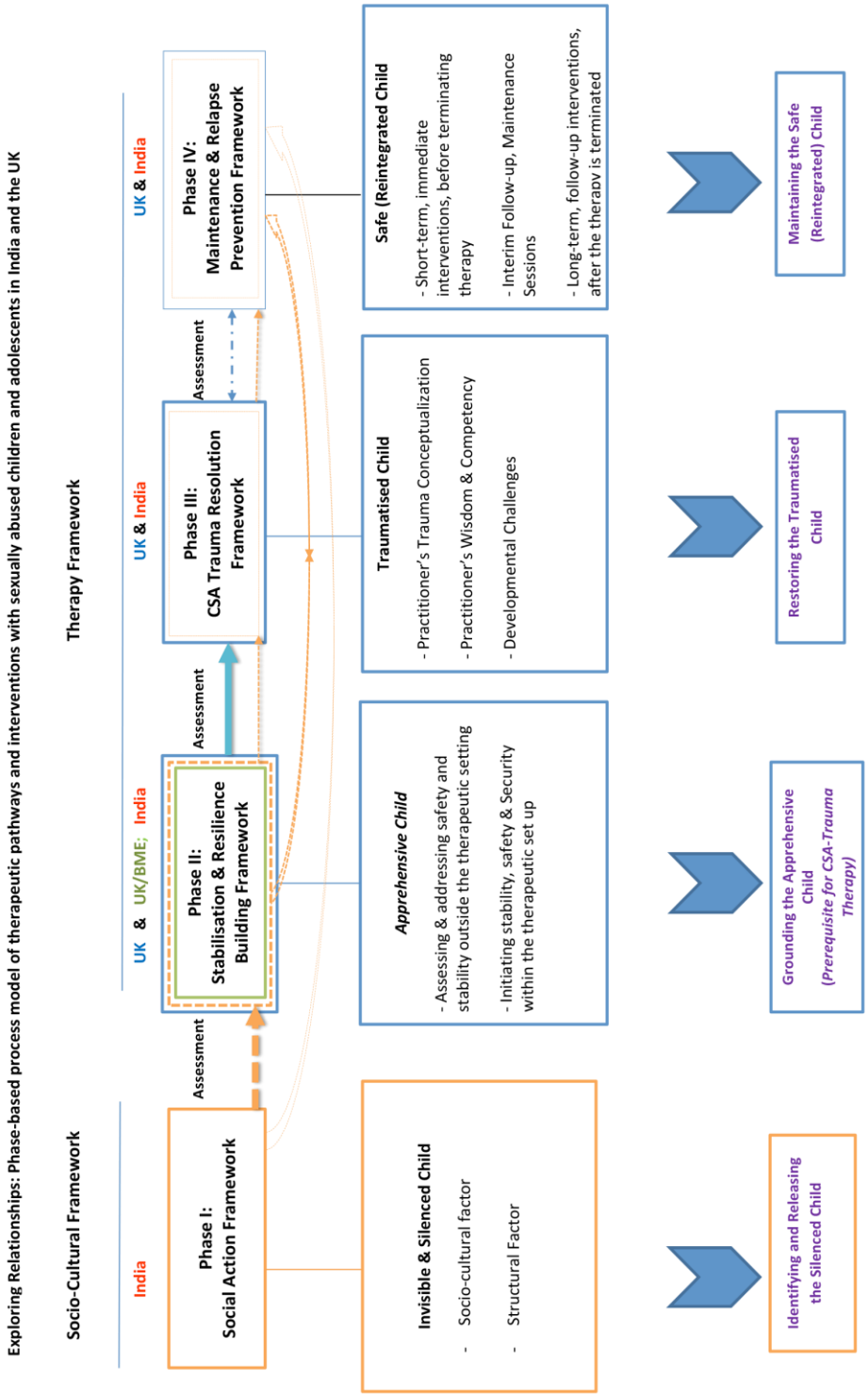
Since the child is in an apprehensive and anxious state when referred for therapy, the key focus of the professionals is to ensure that the child is grounded and stabilised. It is crucial to ground and stabilise the child before progressing to trauma-specific therapy. Trauma-work is challenging for both children and the professionals (vicarious traumatisation).
Pre-therapy assessment and grounding (Assessing and ensuring safety of children):
The first and foremost consideration of the professionals in the UK is if the child is safe to engage in the therapy. This guides the intake of the sexually abused children in therapy. This assessment becomes the prerequisite for professionals to understand if the child is safe and ready to be engaged in therapy.

Based on the assessment of safety, professionals in the UK take decision about intake of a child in therapy. The child will not be taken if not considered to be safe to engage in therapy. The child is refereed back to other agencies for ensuring

safety. While this governs the decision of engaging the child in therapy in the UK, this choice does not exist for the professionals in India although the concern regarding safety of the child is reported to be paramount by them as well. In India, the children are either identified by the NGO professional through the PSE or sexuality education or telephone, where the disclosure by the child is made for the first time and this becomes the basis for taking the child for therapy. Alternatively, usually the mother brings the child for therapy through self-referral or is referred for help to an NGO or a mental health professional in a hospital or institution in two scenarios. One, where the mother notices some behavioural or academic concerns or sexually appropriate behaviours in her child, in which case the disclosure is made for the first time to the concerned professional if CSA becomes apparent during therapy. Second, and a more rare possibility, is that where the child has disclosed CSA by a close family member to the mother. In all these scenarios, the abuser is usually either living in the same family or frequently continues to visit the family, being a close family member. In this case, the focus of intervention in therapy is to facilitate safety of the child and create a safe environment for the child. Different interventions were shared by professionals in India to ensure safety of children including facilitating disclosure through the child to parents.

Similarities in practices and interventions of various professionals in different settings, both in India and the UK, are observed when the initial concerns of physical and social safety are ensured. Emotional safety and stability is the next step of intervention in therapy for stabilising the children and adolescents and engaging them in therapy.

Appendix 12: Memo: Diagrammatic Exploration of Categories



Appendix 13: Self-Audit Checklist for Level 1 Ethics Review

University of Edinburgh,
School of Health in Social Science
RESEARCH ETHICS COMMITTEE

Self-Audit Checklist for Level 1 Ethics Review

The audit is to be conducted by investigators:

- ***For funded research***: *the Principal Investigator.*
- ***For other research conducted by members of academic staff:*** *the academic staff member.*
- ***Postdoctoral research fellows:*** *the research fellow in collaboration with the mentor or proposed mentor.*
- ***Postgraduate research students*** *(PhD and Masters by Research): the student in collaboration with the supervisor(s).*
- ***Taught Masters dissertation students*** *and* ***Undergraduate dissertation/project students:*** *the student in collaboration with the dissertation/project supervisor*

Note: all members of staff and students should conduct the self-audit level of ethics review of their proposed research as part of the proposal process.

1. IRAS or LOCAL AUTHORITY/SOCIAL WORK ethical review
Does the project require IRAS review or other external review including by bodies abroad?

NO

2. Protection of research subject confidentiality
Are there any issues of CONFIDENTIALITY which are not ADEQUATELY HANDLED by normal tenets of academic confidentiality?
NO

These include well-established sets of undertakings that may be agreed more or less explicitly with collaborating individuals/organisations, for example, regarding:
(a) Non-attribution of individual responses;
(b) Individuals and organisations anonymised in publications and presentation;
(c) Specific agreement with respondents regarding feedback to collaborators and publication.

3. Data protection and consent
Are there any issues of DATA HANDLING and CONSENT which are not ADEQUATELY DEALT WITH and compliant with established procedures?
NO

These include well-established sets of undertakings, for example regarding:
(a) Compliance with the University of Edinburgh's Data Protection procedures (see www.recordsmanagement.ed.ac.uk);
(b) Respondents giving consent regarding the collection of personal data;
(c) No special issues arising about confidentiality/informed consent;
(d) application for Caldicott Guardian approval.

4. Moral issues and Researcher/Institutional Conflicts of Interest
Are there any SPECIAL MORAL ISSUES/CONFLICTS OF INTEREST?
NO

(a) An example of conflict of interest would be a financial or non-financial benefit for him/herself or for a relative of friend.

(b) Particular moral issues or concerns could arise, for example where the purposes of research are concealed, where respondents are unable to provide informed consent, or where research findings would impinge negatively/differentially upon the interests of participants.

5. Potential physical or psychological harm, discomfort or stress

(a) Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PSYCHOLOGICAL HARM OR STRESS for participants?
NO
(b) Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PHYSICAL HARM OR DISCOMFORT?
NO
(c) Is there a SIGNIFICANT FORSEEABLE RISK TO THE RESEARCHER?
NO

6. Bringing the University into disrepute

Is there any aspect of the proposed research which might bring the University into disrepute?

NO

7. Vulnerable participants

Are any of the participants or interviewees in the research vulnerable, e.g. children and young people, people who are in custody or care, such as students at school, self help groups, residents of nursing home? NO

8. Duty to disseminate research findings

Are there issues which will prevent all participants and relevant stakeholders having access to a clear, understandable and accurate summary of the research findings?
NO

Overall assessment

If all the answers are NO, the self-audit has been conducted and confirms the ABSENCE OF REASONABLY FORESEEABLE ETHICAL RISKS.

All students (undergraduate, Masters and Doctoral) lodge completed self-audit forms electronically with their supervisor and/or the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area considers the information provided and either confirm ethical approval or refer the request back to the student.

Postdoctoral research fellows lodge completed self-audit forms electronically with their mentor and/or the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area will consider the information provided and either confirms ethical approval or refers the request back to the postdoctoral researcher.

Academic staff (excluding postdoctoral research fellows) lodge completed self-audit forms electronically with the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area will consider the information provided and log the information or confirm ethical approval or refer the request back to the staff member as appropriate.

If one or more answers to the self-audit is YES, level 2 assessment is required. See the School Research Ethics Policy and Procedures for full details. http://www.ed.ac.uk/schools-departments/health/research/policyandprocedures

Name: Javita Narang, PhD Student in Clinical Psychology (First Year)

Date: 24/02/2012

Appendix 14: NHS Ethical Approval Clarification

Email Correspondence

RE: Guidance for ethics approval for PhD research with NHS staff

Bailey, Alex <Alex.Bailey@luht.scot.nhs.uk>

Fri 24/02/2012 10:49
To: Javita Narang <J.Narang-2@sms.ed.ac.uk>;
1 attachment (307 KB)
Governance Arrangements for Research Ethics Committees -- harmonised edition.pdf;

Dear Javita,

As you have stated, projects involving NHS staff only do not require NHS ethics review (as per the attached document).
You should contact your local QIT team with a view to registering your study with them.

Regards,

Alex

Alex Bailey
Scientific Officer
South East Scotland Research Ethics Service
Waverley Gate
Edinburgh
EH1 3EG
Phone: 0131 465 5679 (35679)

-----Original Message-----
From: Javita Narang [mailto:J.Narang-2@sms.ed.ac.uk]
Sent: 24 February 2012 09:56
To: Bailey, Alex
Cc: Matthias Schwannauer
Subject: Guidance for ethics approval for PhD research with NHS staff

Dear Dr Alex Bailey,

I am writing to you to seek clarification and permission regarding the ethics protocol for interviews with Mental Health Professionals/Staff at the NHS Lothian for my PhD research (a brief research note is attached for your kind perusal).

I am a first year PhD (Clinical Psychology) student at the School of Health in Social Science, University of Edinburgh. I am being supervised by Dr. Matthias Schwannauer (Consultant Clinical Psychologist and Head of Clinical Psychology Programme Director, Section of Clinical & Health Psychology, School of Health in Social Sciences) at the University of Edinburgh. Prior to starting this PhD research, I have worked for over fourteen years, on issues related to sexual exploitation including childhood sexual absue, in South Asia.

My research focuses on exploring existing clinical therapeutic approaches and models practiced with child, adolescent and adult survivors of Childhood Sexual Abuse (CSA) and examining their relevance and application in the South Asian context.

I aim to explore the treatment modalities practiced with survivors of CSA by the Mental Health Professionals in Scotland. I propose to interview the NHS Lothian Staff to understand the approaches and models practiced by them and the factors that govern their choice.

I understand that a full IRAS application will not be required for interviews with NHS Staff only. I seek your guidance and ethical approval for the same.

Please find attached a brief note on my research emphasising the purpose, research questions and proposed methodology.

I thank you for your guidance and look forward to hear from you.

Best wishes,

Javita

--
Javita Narang, PhD Student
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